

The impact and consequences of inspection on residential care for older people: A critical analysis of four case studies of Commission for Social Care Inspection (CSCI) inspection

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ABSTRACT

This research examines the impact and consequences of inspection by the Commission for Social Care Inspection (CSCI).

The study begins with a Systematic Review (SR) of existing literature that is divided into effectiveness and process questions. The results of this review show there is no international literature on the effectiveness of inspection at improving residential care for older people. There is also very little process literature.

The second part of the research uses a multi-site case study approach with a longitudinal element, to qualitatively examine the impact of inspection in relation to the quality of care provided by residential care homes for older people. Four CSCI inspectors from four different inspection offices across England took part in the study.

The case studies show inspection struggled to induce quality improvements in services and had little direct impact on residents. A 'culture of ageism' existed within the services and this influenced both provision and residents expectations of care. Provision in all four case studies was still dominated by institutional routine and a lack of service user empowerment.

In this context despite clear evidence regarding the value of outcomes focused care this had, by enlarge, not filtered through to the services in this study and there was still a tendency to focus on outputs without relating these to service user outcomes.

I argue that the complexity of residential care, which depends upon an interaction between environment, care home management, staff, residents, their relatives, and the government inspectorate means that the most successful method of quality improvement comes through partnership and negotiation between the these groups. My findings have shown that it is very rarely one group who is decisive in determining an improvement in quality and that change must come about through negotiation.

Although inspection must incorporate a notion of 'assessment' that is standardised and measurable, it should also encompass professional judgement and actively seek to include

elements of user-expertise. I argue that despite rhetoric that advocates this approach the inspection regime is hamstrung by a particular form of management values and practice. Constant 'modernisation' of the inspectorate has further emphasised a model of inspection that sees care as a series of discrete events, where each issue is clearly defined and decisions are taken by inspectors who choose between a prescribed set of judgement criteria. To this extent inspection is increasingly focused on audit. I raise the question whether in the changing landscape of inspection the CSCI has marginalised inspectors and risks losing a very valuable method of effecting change.

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GLOSSARY

| | |
|--------|--|
| ADASS | Association of Directors of Adult Social Services |
| AQAA | Annual Quality Assurance Assessment |
| CAQDAS | Computer Aided Qualitative Data Analysis Software |
| CH 1 | Care Home 1 |
| CH 2 | Care Home 2 |
| CH 3 | Care Home 3 |
| CH 4 | Care Home 4 |
| CSA | Care Standards Act (2000, 2008) |
| CSCI | Commission for Social Care Inspection |
| CSSR | Council with Social Service Responsibility |
| CQC | Care Quality Commission |
| CRB | Criminal Records Bureau |
| GP | General Practitioner |
| GSCC | General Social Care Council |
| IFSW | International Federation of Social Workers |
| IBL | Inspection for Better Lives |
| IR | Inspection Record |
| KI | Key inspection |
| KLORA | Key Lines of Regulatory Assessment |
| NCSC | National Care Standards Commission |
| NHS | National Health Service |
| NISW | National Institute for Social Work |
| NMS | National Minimum Standards |
| NSF | National Service Framework |
| OECD | Organisation for Economic Co-operation and Development |
| RCT | Randomised Control Trial |
| RM | Regulation Manager |
| SR | Systematic Review |
| SSI | Social Services Inspectorate |
| WCC | World Class Commissioning |

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INTRODUCTION

This thesis reports a study of the character and practice of social care inspection and investigates the relationship between inspection and quality of care in residential care homes for older people.

To do this I examined existing evidence on the effectiveness of inspection by conducting a systematic review of current research. Following this analysis, and informed by the findings, I completed longitudinal, multi-site case studies of four residential care homes for older people to qualitatively examine the consequences and impact of inspection on quality of care.

In these opening pages I outline the reasons for my interest in this topic and the rationale for the study. I go on to describe the main features of the study and the structure of the thesis. These opening pages only describe my initial rationale for developing the study and as such are only lightly referenced.

There is a lengthy academic and policy literature on improving the experiences of older people who receive social care services in England (see Chapter 1). For too long social care service providers have treated users as dependent and frail which has resulted in services with, in general, a very narrow perspective of service aims and delivery. In order to challenge and breakdown this antiquated notion of care within services, through a wide consultation with older people, the government in England has developed seven broad outcomes areas that older people should expect to achieve while receiving social care services:

- Improved health;
- improved quality of life;
- making a positive contribution;
- exercise of choice and control;
- freedom from discrimination or harassment;
- economic well-being; and
- personal dignity.

A large body of evidence (see for example Glendinning, et al. 2006; Hudson, et al. 2005) on the benefit and nature of outcome focused social care for older people, and national policy documents such as the National Service Framework (NSF) for Older People (Department of Health 2001d) and the Green Paper '*Independence, Well-being and Choice*' (Department of Health 2005), suggests that these outcomes can only be satisfactorily achieved if services are provided in conjunction with older people rather than on their behalf. This prevailing notion of service delivery is neatly summed up by Hudson et al (2005: 4):

‘Services developed on a sound understanding of what people believe, want or need are more likely to deliver intended outcomes effectively’

This new outcomes-focused policy direction, coupled with recent scandals in residential care, has redirected attention to the private¹ nature of much social care, and the importance of ensuring the quality of care afforded people who use services.

The role of inspectorates is seen as central to ensuring the quality of care in the UK, with the emphasis being variously on the protection of consumers, the regulation of standards of service, and the regulation of procedures and financial integrity of services (Johnson, et al. 1998). With a refined emphasis on the outcomes of services for those who use them - in the context of the historical inability of residential services to achieve these goals - the improvement potential of inspectorates has been emphasised.

Studies by Gibbs and Sinclair (1992a) and Day et al (1996) suggest local level regulation of residential care homes for older people was ineffective because of large variations in standards across inspection and inconsistent interpretations of standards by inspectors. This led to the conclusion by national policy makers that there needed to be universal standards across the country and inspectors needed to be clear about standards in order to effectively ensure services are not only providing an acceptable minimum standard of care but also working towards constant improvements.

¹ I use the term ‘private’ to convey two meanings. First, residential care provision by private providers. Second, the notion of social care as ‘an invisible trade’ in the same way in which Andrew Pithouse (1999) describes the practice of Social Work.

Based on these concepts the Commission for Social Care Inspection (CSCI) was launched in April 2004, and was created under the Health and Social Care [Community Health and Standards] Act 2003. This Act both transfers powers from the predecessor bodies (the Social Services Inspectorate [SSI], the SSI / Audit Commission Joint Review team, and the National Care Standards Commission) to the CSCI and afforded it new or enhanced powers, especially to encourage and drive improvement in social care.

The Commission's modernisation of the regulation of social care began with the publication of *Inspecting for Better Lives* (CSCI, 2005), which set out a plan for the development of the process of inspection with a specific focus on standardisation and quality as measured.

The rationale for this study follows directly from this strategy. The Commission's scoring system 'makes us focus on each standard rather than whether the people using those care services are getting what they need' (CSCI, 2005a: 11), this reflects Etzioni's observation that 'frequent measuring tends to encourage over-production of measurable items, and neglect of less measurable items' (Etzioni 1964: 9). The newness of the inspectorate and a recently evolved commitment to inspection that focuses on the direct experiences of residents means the appropriateness in terms of both technical function and effectiveness in improving quality has not been examined.

This thesis uses a case study methodology and as such is focused on the English policy model, as this is where the CSCI operates. In the context of devolved government it is no longer helpful for this study to make generalizations about inspection regimes across the four Home Countries. The study was not simply focused on inspection *per se* but on the dynamics and interplay of the stakeholders involved in the processes of inspection and reactions to the findings of inspection.

As of April 2009 the CSCI amalgamated with the Healthcare Commission and the Mental Health Act Commission into one body: the Care Quality Commission (CQC). Although this has an impact on the findings of my thesis, currently the CQC has retained the majority of the CSCI inspection techniques and remains on the path of a stepwise evolution of practice that would have still been occurring should the CSCI have remained. In this context my findings and conclusions have relevance to the wider conceptual debates

about the form and nature of inspection and aim to inform further development of the CQC.

OUTLINE OF THE STUDY

Aims

To explore, from the perspective of inspectors, service providers and service users:

- Existing international literature on effectiveness of inspection on residential care for older people.
- The inspection as an ‘Event’. To appraise the process of inspection by considering how well the process works, what the difficulties are, and areas for development.
- The impact inspection has on service provision – the reaction to inspection findings, the extent to which it leads to improvements over the case study period, the barriers to implementing service improvement.
- The impact inspection has on residents – reaction to inspection and their understanding of the process; the extent to which it improves the quality of service to residents; whether inspection focuses on outcomes important to residents.
- What constitutes good quality inspection of residential care homes for older people?

The design of the study

In addition to a literature review, the study consists of two phases of data collection and analysis. The first phase of the study comprised a systematic review of existing international literature on the effectiveness and impact of inspection on residential care for older people. The purpose of the review was to help identify the quality of the current evidence base and highlight implications for practice and for further research. In doing this it also informed stage two of the data collection. The Systematic Review was undertaken as a one-off endeavour at the start of my PhD as it was required by the CSCI to inform ongoing deliberation and internal policy discussions. As such it stands alone as a piece of work and I have not attempted to update it as this would contradict the rationale for initially undertaken the review.

The second phase of the study utilised a multi-site case study approach with a longitudinal element, to qualitatively examine the impact of inspection in relation to the quality of care provided by residential care homes for older people. Four CSCI inspectors from four different inspection offices across England took part in the study. From their caseloads four residential care homes for older people were chosen as case study sites. These services agreed to be observed for nine months beginning at the point of their next inspection. In total 108 interviews were carried out with inspectors, the respective care home managers, two members of staff working in the service, three residents and their corresponding relatives - all interviewed at the three data collection points:

1. At the point of inspection.
2. A week after the report was sent to the service (approximately 8 – 12 weeks after inspection).
3. Nine months after the inspection.

STRUCTURE OF THIS THESIS

The thesis consists of four parts. The first is a review of the literature. This review starts in Chapter 1 with a review of the general literature on the theoretical underpinning of the model of social care to provide context for inspection. It then proceeds to examine models of regulation and provide a context for the investigation into the CSCI's inspection activity.

The second part consists of a systematic review of the effectiveness of inspection in improving the quality of residential care (Chapter 2). At the outset my sole focus was on effectiveness but after initial scoping work when developing the review protocol I divided the review into two questions, one with a focus on effectiveness and one with a focus on process. As well as reviewing existing literature I also discuss methodological questions concerning systematic reviews, with particular attention to the synthesis of qualitative research.

In the third part of the thesis I turn my focus to a qualitative examination of the consequences of inspection. I begin this in Chapter 3 by discussing my methodology. I give a reflexive account of the development of my thinking about an appropriate methodology for this part of the study, an account of what I actually did in practice, and an

explanation of how my approach draws on the literature about research methods.

In the fourth part of the study I present the findings of the qualitative study. This begins in Chapter 4 with an account of the ‘Event’ of inspection, where I observe and reflect on the process, supplementing the data with interviews of the four inspectors directly after they conducted the inspection. In Chapters 5 and 6 I turn to looking at the impact of inspection on the case study services over the 9-month study period. Chapter 5 examines the impact on the service, with focus on how managers and their staff reacted to the process of inspection and, over the longitudinal period, to the findings of the inspection report. Chapter 6 turns my attention to the residents in the case study services and examines the impact inspection had on the group on which its aims are focused. In Chapter 7 I use interviews with all participants, as well as themes from the proceeding three chapters, to build a picture of what constitutes good quality inspection of residential care homes for older people.

In the fifth and final part of this thesis, Chapter 8, I draw together my conclusions by synthesizing the key findings of the study, drawing conclusions for policy and practice, and reflecting on both my methodological and analytical approach.

CHAPTER 1: A MODEL OF RESIDENTIAL SOCIAL CARE FOR OLDER PEOPLE

This chapter discusses the development of social care in England in order to understand the rationale for a study into the impact of inspection on older peoples' residential care.

THE STATE OF SOCIAL CARE IN THE UK

In the UK alone £8 billion was spent on personal social care services in 2004/5, and the most conservative forecast projects that this will increase 139 % by 2026 (Wanless 2006: 72). At any one time, up to 1.7 million adults and 400 000 children and families rely on social workers and social care staff for help and support (Commission for Social Care Inspection 2005). As these figures suggest, social care pervades the lives of a significant proportion of the UK population and represents a sizeable but, according to recent independent and government figures, (see Wanless 2006; Local Government Association 2006) currently insufficient portion of public spending. These figures take on added significance if we consider that people who come into contact with social care services are often the most vulnerable and/ or excluded people in society – precisely the people who benefit the most from collective assistance. That is not to say that individuals who are vulnerable or excluded cannot speak or act for themselves, but they require some form of assistance from the state to either protect them from the dangers of (in the case of, for example, neglected or abused children), or facilitate their active participation in (in the case of the physically disabled), society.

It is inevitable that older persons' social care is going to take on a much more important role as the post-war 'baby boomer' generation enters the later stages of their lives. The Organisation for Economic Cooperation and Development (OECD) predict that in the UK the ratio of the population aged 65 and over to the population aged between 20 and 64 will rise from 27 % in 2003 to just under 50 % in 2050 (OECD 2004). Evidence suggests that due to demographic and sociological changes it is unlikely that families will be able to play such an important role in care (Assous 2001). This means that in the future there is going to be an ever-increasing strain on the UK's public service infrastructure and a need, more than ever, to produce efficient, cost effective social services.

In this context, at the start of the twenty first century social care operates at a crux of society, bridging the gap between tensions created, on one hand, by a desire for an egoistic, consumer driven lifestyle and, on the other, altruistic, caring tendencies of social justice delineated by society's shared values and beliefs (such as conceptions of human rights and citizenship), which Durkheim (1984) termed 'mechanical solidarity'. In the post-war period the focus of both theory and policy has been on achieving a balance between altruistic and egoistic tendencies and providing the necessary infrastructure to allow this to happen. During the last two decades the focus in the public sector has shifted from a socialist ideal of equality and provision for all, to the pragmatic solution of opportunities and choices available to individuals in a mixed economy of services (Jordan 2005a). However, along with choice and opportunity comes a shift in accountability and a dilution of solidarity brought about by a greater individualisation of risk. Analysis of the relationship between globalisation, individualisation and the service economy has shown that constraints on national government spending can be directly related to the mobility of capital (Scharpf 1999) and this produces greater inequalities of incomes (Iverson and Wren 1998). Liberal, Christian Democratic and Social Democratic regimes have all, in their own ways, tried to adapt to the economic imperatives of mobile capital while adjusting their social policies to protect the most vulnerable populations from the impact of global change (Hood, et al. 1999b). The debate about how to deliver social care is a reflection of wider themes in the national policy agenda (choice, individualisation versus pooled risk and solidarity), which address the nature of social inclusion and citizenship and form the debate on how to best promote social welfare.

It is in this context that I situate my research into the impact of inspection. In the remainder of the chapter I will trace the development of the shift in service provision from an ideological driven model to the current pragmatic model of choice and empowerment. I will discuss how this model of provision has developed through a re-conceptualisation of the concept of citizenship. I will then argue that in the context of this conceptual shift regulation has become the primary tool in protecting citizenship rights and upholding a notion of social justice within social care. I will also discuss the impact and merits of this change and the implications for service users. I will proceed to discuss regulation of older peoples' social care and, using this specific field of care, show why research into the process, impact and consequences of inspection is important; specifically the role of the CSCI into which there has been little research.

JUSTICE, CITIZENSHIP AND HUMAN RIGHTS

A concept of citizenship defines the rights and obligations to which an individual of a state or community subscribes, these rights centre around three main areas: civil (e.g. free speech and movement, rule of law), political (e.g. right to vote, run for electoral office) and social (e.g. welfare, health care, unemployment support) rights (Marshall 1950). The function of the social service sector is to operationalise a conception of social justice into practice and facilitate the social rights of an individual or collective. In any society or nation state a typology of rights (that may be manifest in many different forms) dictates the way in which citizenship may be attained and is dependent on prevailing national frameworks of political democracy, welfare state and market economy. A concept of citizenship is dependent upon these factors and the role of welfare policy can be seen as being bound with society's concept of citizenship. Welfare policy of a particular state is influenced by the prevailing concept of citizenship (along with political and economic considerations – which themselves are born out of citizenship ideology). In the UK welfare policy works to allow everyone in society to access the same rights as citizens, helping those who are in a position of disadvantage or social exclusion that is preventing them from fulfilling their role as a citizen; for example, helping people with physical disabilities to enter work by facilitating their access to the workplace. In the context of a concept of citizenship social services act as means of solidarity, redistribution, equality and security (in the form of pooled risk) within society, by providing infrastructure to facilitate appropriate interactions between equal and interdependent citizens (Dean 2004). Thus the framework for social service infrastructure is determined by the prevailing concept of citizenship.

Defining Citizenship: a critique

Since its inception in ancient Greece around 700 B.C. a concept of citizenship has been used as a basis for rights and entitlements afforded to individuals under the jurisdiction of a state or nation. The issue of citizenship has been a central, but contested concept within policy discourse and there has been debate, both within and between nation states, over the nature of citizenship and the modes of protection and obligation it dictates. While there is a broad agreement on the need for pooled resources, there are conflicting ideas of who should be entitled to enter into any solidarity agreement and who should be protected under the title 'citizen'.

T. H. Marshall (1950) wrote the twentieth century's seminal work on citizenship. He offered a historical description of the development of industrial societies. His classic formulation of citizenship contained three main elements, which developed over proceeding centuries. First, in the eighteenth century came civil rights, which dictated the establishment of legal citizenship and the notion that all citizens were of equal standing in relation to the law. Second, in the nineteenth century came political rights, which allowed the access of all citizens to the democratic apparatus that exercise political power (although not for all until the early 20th century). Third, in the twentieth century came social rights, which established the provision that all citizens should have sufficient means to engage fully in society (Marshall 1950).

This Marshallian typology has been widely criticised as too narrow, neglecting the rights of women, minority cultures and unpaid workers (such as carers) amongst others (see Arksey, et al. 2005; Levitas 2001; Lister 1990; Sevenhuijsen 1998). It has been accused of forcing social exclusion on those who cannot participate in the prevailing notion of society. In this sense citizenship is a 'contextualised concept' (Siim 2000: 1), because minority groups experience exclusionary citizenship practices and battle for full inclusion 'from the vantage point of specific, differentiated cultures and practices of citizenship as they are consolidated in the countries in which they live or are forced to live' (Saraceno 1997: 32).

These various criticisms prove that a Marshallian typology of citizenship is not appropriate to ensure the rights of vulnerable people are upheld (Lister 2001). Esping-Anderson (1990) attempts to approach the concept of citizenship in a different way, by analysing the welfare policies of states and categorising them into three broad typologies. These typologies reflect the state's approach to citizenship because contrasting approaches to welfare are underpinned by the rights of individuals as defined by the prevailing concept of citizenship.

Esping-Anderson (1990) develops a typology of welfare states in the context of a concept of citizenship. To do this he includes a political dimension in an attempt to ally the normative concept with prevailing political ideology and understand how citizenship is facilitated across western states. He conducted a comparative study of different countries across the Western world and developed a typology of welfare states that takes into

account political forces in its analysis. His widely regarded book 'The Three Worlds of Welfare Capitalism' (1990) analyses different types of capitalist welfare state regimes that exhibit contrasting levels of generosity. His argument is that different countries organise social policy provision around three main features:

1. Level of state intervention
 2. Stratification of social groups
 3. The extent of de-commodification
- (Manning 2003)

Countries can be classified into three welfare provision types, dependent upon the effects of these three criteria on the welfare effort of a particular country. The first are '(neo-) liberal' welfare states, which exhibit a low level of state intervention to encourage the market; this creates a large stratification of social groups in terms of income equality as benefits are often minimal and associated with stigma and a low level of de-commodification. Second, 'corporatist' regimes exhibit high levels of de-commodification through regulation of non-profit providers of social welfare, which leads to high levels of stratification (through both income and social status). The third, and as Esping-Anderson points out 'clearly the smallest' (Esping-Anderson 1990: 27) welfare regime is made up of countries where 'social democracy was clearly the dominant force behind social reform' (Esping-Anderson 1990: 27). From this perspective the nature of the welfare state is very much dependent on political decisions, especially the alliances that form between different social classes (Manning 2003).

It is argued that neither Marshall's normative concept nor Esping-Anderson's political typology offers suitable, uncontested analysis of modern citizenship. In Britain Government social policy today has followed the cultural shift in economics towards individual autonomy, mobility and self-realisation (Giddens 1991, 1992, 1999) in order to form the basis of a new ideology of 'social (or active) citizenship'. Although there has obviously been a shift in middle class interest from a state provision of welfare, the shift in the UK is also deeply rooted in political forces, which Esping- Anderson (1990) identified as a crucial factor in state welfare regimes. Rather than simply having a reciprocal relationship where the citizen works, pays taxes, serves on juries and defends the state (when appropriate), and in return the state offers protection and shared risk, this new concept requires citizens to seek fulfilment of their own potential by being responsible for choices in education, health and welfare. In return the government provides opportunities

for enterprise and restructures public services, to allow citizens to choose the type of service they want and make choices between suppliers, using evaluative information published by official agencies and regulators. In essence the New Labour notion of 'social citizenship' was summed up by Tony Blair in a 1996 lecture to the Fabian Society:

'A modern notion of citizenship gives rights but demands obligations, shows respect but wants it back, grants opportunity but insists on responsibility' (Blair 1996: 218)

It is a concept that has a lot in common with Marshall's (1950) notion of 'strong citizenship'. New Labour accepts that the state should assume some responsibility for creating job opportunities and work training opportunities. But in return citizens have a responsibility to make the right choices and take up opportunities. Otherwise they can expect little support from the national government in the form of welfare.

A conception of citizenship underpins political structures and, in conjunction with technical considerations, provides the basis for their construction. I will now proceed to discuss the development of social care provision in the UK and trace this in conjunction with the prevailing conceptualisation of citizenship and rights.

MODELS OF SOCIAL SERVICE PROVISION: A REFLECTION OF THE PREVAILING CONCEPT OF CITIZENSHIP

Ever since the inception of 'Social Insurance and Allied Services' in 1942 there has been constant ideological and practical debate in Britain about, not only how welfare provision should be funded, but also how it should be administered and controlled. Prior to changes that began in the 1980s services were administered in a 'top-down' manner, in which civil servants controlled the provision of services. The belief was that civil servants were professionals who were in the best position to provide fair and effective universal services underpinned by a notion of 'unconditional positive regard' (Thompson 2005: 119-20); where services are provided to anyone who needs them irrespective of ability to pay or affiliation.

However, in the 1980s this notion began to change. The election of the Thatcher government in 1979 represented a clear break with past community care policies, particularly with regard to the reduction in the role of local authorities as service providers and the promotion of private, for profit provision (Barnes and Walker 1996b). The idea of 'value for money' rippled through the 1980s and early 1990s, which led to a drive for greater financial prudence and management of the UK economy; there was no longer the guarantee of year on year public expenditure growth (OECD 1994). A lot more emphasis was placed on planning, with calls for greater accountability and justification of actions from those (individuals or companies) that provide public services. Thus notions of participation and acceptability on behalf of the citizen (consumer) became important drivers for the need to measure performance and ensure quality. If the government was no longer to provide services then it must at least ensure a minimum level of quality in order to fulfil its role as a guardian of society's collective good. With the principle of individual choice and accountability enshrined in service provision the main debate today concerning provision of social services comes from whether notions of participation and accountability should be enacted through a combination of consumerism, and the forces of the market and citizenship rights.

New managerialism: the political zeitgeist of public service provision

In the 1980s under a Conservative government led by Margaret Thatcher a consumerist method of providing social care came to the fore. This change in political ideology and working came from a shift in values by central government, which led to the rise of 'new managerialism' (Davies 1987) within the social services and led to what Rouse (1997) summarises as: management decentralisation, financial devolution, 'new' human resource management, strategic thinking and a quest for quality. The new ideological approach to managing public services, was underpinned by a belief in the 'state regulation of and manager power over services and their employees' (Deem and Brehony 2005: 219).

Stemming from a fear that the market could be swamped by an exponentially increasing number of dependent older people this market ideology was reinforced by a familiarist ideology that stressed individualism, insisting that in the main older people should depend on care provided by their families, rather than the state. With these changes came a seismic reprisal of the technologies and functions of the public sector, leading to a focus on

judging the performance and quality of the services on offer using performance reviews and measurement of efficiency and effectiveness. This shift in agenda can be seen across societies and is characterised by certain features: the creation of a mixed economy of welfare, diminution in the role of the state and increase in the role of the 3rd sector; the separation of provider and funder roles; care packaging and the beginnings of a policy tailoring services to individual users (Barnes and Walker 1996b: 375).

Researchers have identified that this movement was not just about social justice and efficiency of provision, but about doing *different* things by transforming services to make them fit within technologies that managerialism brings to them (Hough 1995). The effect of these multitude of new managerial influences has caused problems for end users and in some ways marginalised empowerment and choice by forcing service provision process and care outputs to be construed by recording formats and practice guidelines (Carey 2003; Dearmen 2005). Indeed instead of helping services improve and deliver better services in partnership the monitoring and constant surveillance has often become the focus of service providers (Harlow 2004).

The move towards marketisation induced some real problems amongst users of services (Barnes and Walker 1996b). Harding and Beresford (1996) in a report for National Institute for Social Work (NISW) found that service users were complaining about the lack of organisation and responsiveness to needs within the new market driven sector. Carer groups, along with support from researchers have shown that policy in the 1980s took the carers role for granted and justified this as part of familiarist ideology (Hirst and Arksey 2000). Taking this position allowed the government to ignore a large proportion of the vulnerable population because according to the neo-liberal model it should be taken care of in the private sphere. Consequently the government did very little to support the activities of people who were caring for dependent family members (Twigg, et al. 1990).

The 1990 NHS and Community Care Act represent the culmination of policies throughout the 1980s and established a new framework for services based on these principles. In building on these principles the Act entrenched 'marketisation' into the UK social care field, not only promoting privately run services, but also creating a 'quasi-market' within social services (Le Grand and Bartlett 1993). The Government White Paper that led to the 1990 Act, *Caring for People* (1989a), justified this change as 'giving people a greater

individual say in how they live their lives and the services they need to help them... (*by offering*)... a wider range and choice of services for the consumer' (Department of Health 1989a: 2). However, while the Audit Commission, working to implement the 1990 Act claimed 'The first aim is to empower the service users and their carers' (Audit Commission 1992: 11), the only input into provision that the service user has under this model was a very simplistic notion of 'exit' – that they can choose to not purchase a service (Marquand 2005). In practice this is not viable and in a lot of cases people were still passive receivers of care: if an individual needs a bed in a residential care home because they can no longer support themselves in their own home, or a person needs help to get out of bed in the morning after they have fallen and injured their hip they cannot choose to simply not purchase a service because they do not deem it to be appropriate or of sufficient quality.

Many of those who are frail are unlikely to be in a position to 'shop around' so have no real prospect of exit unless this principle is supported by the state, rather than leaving the individual to negotiate the market on their own. This meant that there was a dispute about how the individual should be involved in their role as a citizen. The model is also problematic because although service users may be able to purchase elsewhere the White Paper still envisages 'Care Managers', professionals who will determine packages of care, thus marginalising the individual. Consequently there is less scope for innovation because there is little or no involvement of the service user. A purely consumerist model also leaves service provision open to the 'tyranny of the majority', where priority is given to specific common needs and other services, which are less economical to provide, become marginalised, or in the worst case scenario do not survive – leaving the people who benefit from that care marginalised.

This market-driven model retains some of the problematic features of the 'top-down' state-led model of the early welfare state, which made people passive recipients of professional interventions. It also meant the removal of solidarity and a shift in accountability towards the individual, making them responsible for making their choices as a consumer, rather than allowing the state to carry the burden.

In this context the ideological shift has also been characterised by a new kind of state regulation in the form of performance indicators, league tables, benchmarking and

performance management through pre-ordained targets (Hood 1991; Kirkpatrick and Lucio 1995). As Munro explains regulation allows the government to check:

‘...whether procedures were properly followed (rather) ... than whether the professionals made accurate assessments’ (Munro 2004: 1090).

21ST CENTURY OLDER PERSONS’ SOCIAL CARE IN THE UK: HOBSON’S CHOICE?

The influence of third way ideology over politics since New Labour came to power in 1997 and its insistence on a choice agenda in social care has led to questions over both the efficacy of the policies (both long and short term) and the suitability of the mantra. Do current older persons’ social care policies offer choice or is the choice agenda simply a slogan, which if repeated often enough pushes the right buttons with the general public, but when analysed is simply a tautological reification of a system that has changed the process of providing welfare (to favour individual autonomy over state accountability) but in fact offers no greater choice?

The central tendencies of New Labour’s older peoples’ welfare reforms agenda have been articulated by Giddens since the middle of the 1990s. He claims that

‘Old age at sixty-five is a creation, pure and simple, of the welfare state. It is a form of *welfare dependency* much more widespread than any of the dependencies noted by the rightist interpreters of the underclass’ (Giddens 1994: 170).

Giddens argues that old age at sixty-five is a social creation resulting from outdated concepts of the welfare state. From this perspective people over the age of sixty-five are conceived as a financial and medical burden; a position that has been forced upon them. Society has constructed a notion that once people reach sixty-five they are disqualified from full membership of society and need to be looked after by the rest of the population. By arguing this in the mid 1990s Giddens, and New Labour policy makers, were able to claim that themes of dependency and passivity induced by the welfare state are neither good for individuals nor society as a whole. The publication of ‘New Ambitions for our

Country' (Department of Social Services 1998) was primarily concerned with shifting responsibility away from what New Labour see as passivity and dependency on services administered by the state. The policy continued in the direction of the Conservatives' conceptual shift, from the belief that the state should provide adequate support and welfare for those who are excluded from participation in mainstream society for reasons of health or circumstance, to empowerment and choice where individuals are 'consumers'; able to make decisions tailored to the best welfare support for them, administered by a mixed economy of services, and supported by an invigorated information agenda of accessible assessment and evaluation. While this re-conceptualisation of old age is entirely appropriate because the historically held opinion that older people are helpless is a fallacy, if this conceptual shift is used to move accountability away from the state and shift the burden onto the individual then there are both moral and practical questions to be asked.

There was undoubtedly a political consideration in the re-conceptualisation of citizenship and the implications of this for older peoples' care provision. State provision had become widely derided as inefficient (Clarke and Newman 1997). The implications for cost coupled with the ever-increasing older population meant that without a significant increase in taxes for the population the means of provision would have to change. To increase taxes was deemed to be political suicide, so change and efficiency savings were necessary. A primary tactic in this change was a shift towards third sector provision and a greater involvement of the service user.

This shift in agenda also came from the practical need for welfare reform. The OECD claim that the welfare state could not have survived if it maintained the Beveridge ideal, problems associated with ageing alone would bring it to its knees (see OECD 2004). However, the road of choice and empowerment was a political option, born out of ideology as much as pragmatism. As the Scandinavian model demonstrates, state administered welfare can be effective if governments are prepared to raise taxes. As in Scandinavian countries a political decision to justify the imposition to raise taxes could have been made. The choice to shift responsibility onto individuals and treat services as analogous to goods has been preferred and justified as progress; but there is considerable doubt as to whether this is to the benefit of either individuals or society.

Indeed this shift in responsibility, pushed by New Labour as new and progressive, can be traced certainly to the Thatcher government of the 1980s. The conservative notion of a 'dependency culture' in Britain during the 1980s led the neo-liberal reform government of Margaret Thatcher to lay the foundations for New Labour's policies by beginning what David Marquand sees as a crucial '*kulturkampf*' (Marquand 2005: 105) between the state and 'the ethic, culture and operational codes of the public domain' (105). They did this by arguing, as Nigel Lawson did in his book *The View from No. 11*, that they needed to '... change the entire culture of a nation from anti-profits, anti-business, government-dependent, lassitude and defeatism' (Lawson 1993: 64-5). By rooting out these anti-market sentiments the Thatcher government opened the public domain to market forces by changing attitudes and behaviour of the public and neutralising public institutions and practices. As Marquand points out 'the crusade did not follow a predetermined path, derived from a carefully considered strategy' (Marquand 2005: 106), but as with most political action followed an organic, piecemeal trajectory.

Is an active citizenship model of welfare appropriate?

A key question to address the success of New Labour's choice agenda is to question whether a choice in services is improving our subjective well-being? Research suggests that despite increases in income, subjective well-being of the population is declining (Helliwell 2002). It has stalled as a result of 'hidden costs' in the choice / opportunity agenda that has permeated Anglophone countries. It is argued that the erosion of solidarity and the extra stress as a result of individual autonomy (financially, politically and socially) over decision-making is responsible for the stagnation of subjective well-being. Although the Government presents schemes where the individual is in control, the primary stakeholder in their own welfare, it is plain that they are expected to make the **right choices**. As Mann points out individuals are expected to 'be saving more, working for longer and expecting less from the state' (Mann 2006: 79).

To make choices requires careful consideration and sufficient information to make an informed decision. In the case of social care, the Commission for Social Care Inspection (CSCI) offers detailed reports of care services which stakeholders can consult before they make their decision on which to choose. However, for those who make the wrong choices CSCI also has the power to recommend the closure of a service despite the 'choice' (of

course in reality this may not have been a choice due to external constraints) that stakeholders have made. Policies led by this agenda aim to promote a certain type of consumer but cannot do this in a completely free market, because of popular attachments to certain public provisions and highlighted previous failures in the private market (e.g. the case of staff from the Welcome Care Agency in Birmingham feeding a home care client talcum powder (Carvel 2006)).

The jury is still out on whether a social care service centred around the conception of social citizenship is promoting better lives for the vulnerable population of Britain. Are choices in social care really improving older peoples lives? Some have argued that the choice agenda has been deficient in producing greater happiness and well-being than collective, state-led provision that offers solidarity as the fabric of society; a 'social glue' (Jordan 2005a).

Older persons' residential care: A focus on outcomes

Challenges to a concept of ageing that characterise older people as requiring a decreased need for social engagement have been articulated since the 1950s (see for example Shanas 1962; Townsend 1963; Tunstall 1966). The Joseph Rowntree Foundation, in a project designed and implemented by older service users, identifies current social care as still largely operating on a 'deficit model' of service provision:

'In this model old age is seen an illness for which there is no cure, with the 'patient' losing rights because of the need to accept health or social care interventions to treat their ailments or to minimise risks' (JRF 2004: 12)

This means there is a need to confront stereotyping and challenge ageist perceptions, which Department of Health and academic evidence suggests is still a facet of service provision. Prevailing political and social conceptions of an active citizenship model of welfare provision mean that empowerment is seen as the way to reframe negative conceptions of old age, using older people themselves to control their own service delivery.

In this context there has been a large amount of research into what service users want from the social care they receive. In challenge to former negative conceptions research has

shown that good quality care is best delivered if the services focus on outcomes for service users (Glendinning, et al. 2006; Netten, et al. 2005; Netten, et al. 2002). Glendinning, Clarke et al (2006: v) developed three very useful outcome groups older people identified as being important:

Outcomes involving change

- Improvements in physical symptoms and behaviour.
- Improvements in physical functioning and mobility.
- Improvements in morale.

Outcomes involving maintenance or prevention

- Meeting basic physical needs.
- Ensuring personal safety and security.
- Having a clean and tidy home environment.
- Keeping alert and active.
- Having social contact and company, including opportunities to contribute as well as receive help.
- Having control over daily routines.

Service process outcomes

These refer to the ways that services are accessed and delivered and include:

- Feeling valued and respected.
- Being treated as an individual.
- Having a say and control over services.
- Value for money.
- A good 'fit' with other sources of support.
- Compatibility with, and respect for, cultural and religious preferences.

In terms of policy this evidence has manifest in a set of condensed broad outcome areas:

- Good social relationships
- Standards of social comparison and expectations in life
- Involvement in social and voluntary activities

- Pursuing personal hobbies and interests
 - Good health and functional ability
 - Feeling safe
 - Psychological well-being
 - Feeling valued and respected
- (Department of Health 2005)

Service users feel that good quality social care is exhibited when care homes provide a safe environment, which assesses residents' needs, provides assistance where it is required and gives the residents the opportunity to live a good quality of life. These findings are supported by the International Federation of Social Workers, who state in their 'International Policy for Older Persons' policy paper that older people should be able to 'exercise the right of self-determination and choice' (IFSW 1999), pursue their interests, and have the right to 'protection, empowerment, initiation and support' (IFSW 1999) while receiving care.

In line with government agenda the focus of social care is now firmly based on creating choices, opportunities and interdependence for service users and 'embedding these new approaches into the social care system's culture and practice' (Department of Health 2005). To achieve this the government is committed to fund user-controlled organisations in order to create a 'participatory process of social care development' (Wistow 2005). But along with these new 'rights' come the 'responsibilities' rooted in the consumerist model.

According to the government White Paper *Our Health, Our Choice, Our Say* care services should be focused on an 'outcomes led approach', judged on the extent to which they contribute to older people achieving their desired outcomes; to achieve this services should work in partnership – both between agencies and professions (Department of Health 2005). The regulatory agency, in the case of England the CSCI, has a responsibility to ensure that service users receive good information with which to make choices about their care and ensure a minimum standard of care in order to protect the safety and well-being of service users.

A MODEL OF REGULATION AND INSPECTION

Having established the political context of social care provision this section attempts to understand the role of inspection within the regulatory model of social care.

Modes of regulation

There are four ways to regulate social care:

1. The first is through **public regulation**: commissioning an independent, public service body to oversee social care services by policing their operation and encouraging improvement through enforcing standards and working with service providers, within the public and private sectors, to drive up standards.
2. Secondly care could be left to the **forces of market competition**, which in theory should eliminate poor providers. However, there is no evidence to suggest that competition takes the form of rivalry to push up quality, rather than keeping prices down and profits up.
3. Third would be to rely on the **self-regulation** of providers, using accreditation by provider associations in place of public regulation. However, this would inevitably be perceived as self-fulfilling and lacking legitimacy. Organisations cannot be trusted to regulate themselves effectively. History has shown that in a liberal economy independently run, commercial businesses will inevitably primarily function within their own economic interests in an attempt to maximise profit, with all other functions, including standards of care, only existing secondary to this *modus operandi*. They must therefore be monitored, checked and scrutinised by external agencies in order to be held accountable (Hood, et al. 1999b)
4. Finally regulation could be left in the hands of local authority purchasers, regulating by ceasing to buy from poor quality providers and using bulk **purchasing power** to force providers to drive up quality or face a drastic reduction in income. This method would leave self-financing users unprotected and create the possibility of them being left to purchase from the poorer quality services which local authorities decline to buy from due to concerns about standards.

These forms of regulation can be characterised in a matrix of *public* or *private* and *economic* or *social* (see Table 1). The vertical axis of the matrix demonstrates regulation that takes place within either the public sector, if the work is conducted transparently and subject to public scrutiny; or in the private sector if it is conducted ‘in-house’ or by co-operatives who represent the interest of the organisation being regulated. The horizontal axis of the matrix demonstrates how regulation can be characterised as either proactive, when it is conducted in response to a set of devised criteria that need to be adhered to in order to ensure minimum safety and consistency amongst services, or responsive when regulation is left to actions made in response to economic or social failings:

Table 1. Matrix of regulatory frameworks

| | Proactive | Responsive |
|---------|--|-------------------------------|
| Public | (1) Public body regulation | (4) Local authority purchases |
| Private | (3) Self-regulation by provider associations | (2) Market competition |

A system that only acts responsively to a situation once a significant incident occurs or set of concerns has been raised, does not provide effective safeguarding of people who use services; it is simply securing the gate once the horse has already bolted. Similarly a system of privately operated regulation, conducted by providers themselves is not acceptable for a service which deals with individuals’ safety and well-being; it lacks legitimacy in the eyes of those who use the service, and is often self serving. A proactive situation in which an independent, publicly accountable regulator works with service providers and users to co-operate in defining standards of practice and implements these standards in a transparent, effective manner (number 1 in Table 1) is the optimum method of regulation for a service which deals with the safety and well-being of a vulnerable section of the population.

The administrative prerogative in public body regulation

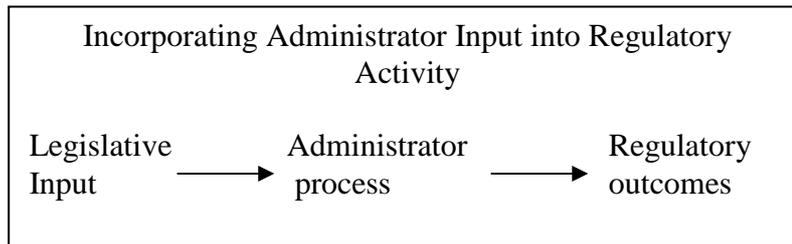
The work of regulatory bodies has a defining impact on regulation outcomes but traditional analysis of the regulatory process predominantly focused on legislative inputs as the

primary factor in regulatory decision-making. In other words, it is often implied that it is possible to explain and predict regulatory outcomes without any attention to either the processes involved in implementation, or outcomes generated (Macdonald 1999). Instead regulatory outcomes are seen to be a direct result of legislative inputs, inferring legislators' incentives and impediments are key to understanding regulation. Yet as Croley points out, the administrative process remains implicit in any theory of regulation (Croley 1998). In fact government can affect only limited regulatory change without relying on regulatory bodies. So within this thesis I aim to address the deficiency of research in process and impact of inspection by considering the views of the stakeholders involved and in doing so explicitly highlight the role of the administrative process in regulatory decision-making.

Regulation of social care in the UK demonstrates the importance of the administrative process and shows how the appointed administrative body is required to do the bulk of the regulatory work. Administrative agencies inevitably fill the gap in legislative policy and these 'gaps' often constitute much more than minor details, allowing the regulatory body to interpret legislation and effectively shape regulation. Legislators determine specific key standards (usually around safety and consistency of service) and a broad ideological position (e.g. equality of service; individual choice), but the regulatory body interprets how to define and apply the legislation, providing it with scope to define meaning. Currently in the UK the Care Standards Act (2000) created the broad remit for regulation in the Social Care sector and established the CSCI as the regulatory body. In effect government regulates by deferring decision-making to administrative bodies, whose activity is shaped by legislated rules and practices but which are open to interpretation and elaboration by professionals (Croley 1998).

The CSCI not only implements the regulatory process but crucially in relation to extent and influence over regulatory decision-making it also has a remit to develop the knowledge base of social care by informing government decision-making, by making annual reports to parliament and promoting 'improvements in social care for the benefit of people who use care services' (CSCI 2006d). The influence the CSCI has on regulatory outcomes is extensive and any theory of regulatory impact needs to take administrator influence into account. Table 2 shows the process of government regulatory activity:

Table 2. Incorporating Administrator Input into Regulatory Activity



While legislative incentive and constraints should not be elided, given that legislators do not directly regulate, any attempt to explain regulation by only alluding to legislator motivation is misguided. There has to be an examination of the processes by which legislative incentives and goals are implemented, sustained and altered. A prime example of the influence that regulatory administrators have over outcomes can be demonstrated by CSCI's implementation of the Inspecting for Better Lives (IBL) programme, a new method of inspection that required no change in legislation but which aims to drastically alter inspection process outcomes. By focusing on effecting changes through dramatically increasing the elicitation of service user views and acting more frequently and efficiently in direct response to these views, the CSCI hopes to more effectively improve outcomes for the individuals who use social care services and improve its regulatory activity. A regulatory shift designed and implemented by administrators, rather than legislators, of regulation.

Assessing the impact and effectiveness of inspection

In order to understand how effective inspection works and what it does, it is helpful to break down the 'regulatory environment' into a structured framework. The terms 'inspection', 'audit' and 'regulation' tend to be used interchangeably, however a regulatory organisation uses many instruments to assess the behaviour and function of services. Instruments currently used to regulate performance include registration of providers, site visits (to examine organisational process and records), review of strategic plans, assessment of performance indicators, financial reviews and annual reports (Boyne, et al. 2002).

Inspectorates have a dual role, which is usually explicit, of both policing and raising standards of the service or institution being inspected. Policing involves detecting and dealing with failures to provide services to a minimum standard. These standards can be developed in two ways: they are most commonly provided for by government legislation, or less frequently can be devised by consultation of all stakeholders with interests in a particular regulatory field. Raising standards is achieved by increasing the knowledge base of the particular area or field being inspected and devising strategies to work in conjunction with the service provider to encourage improvements in performance and facilitate the timely adoption of new trends and improvements. However, the effect of inspection at raising standards is by no means proven and certainly in terms of education, where there has been a comparatively large amount of research, the results are mixed (Cullingford 1999b). Inspection can also have a third, less explicit, ‘symbolic’ importance; offering reassurance to those using or intending to use the service, regardless of the regulators actual impact. While symbolic importance may not be particularly significant from an efficacy point of view (although one would expect inspection which has been proved effective to offer a greater symbolic importance because the inspection regime is well regarded), it is influential on the opinions of service users and therefore the perceived impact of inspection. This is most effective when the regulator is held in high public esteem.

According to Boyd and Walshe (2005), in their systematic review of literature on the impact of regulation of healthcare provision, there are a number of typologies that describe regulation in a number of different environments. Having examined these, and considered them in relation to social care regulation, I agree with Boyd and Walshe and find it useful to analyse the regulatory environment as broken down into four components – **(1) purpose and objectives; (2) regulatory agency; (3) the range, nature and scope of the regulated organisation; (4) and the legislated regime of regulatory organisations.** These four normative components deserve further attention within the context of social care, before consideration of the regulation of social care in England. I will examine them in turn:

1. Purpose and objectives

Boyd and Walshe (2005) consider the **purpose and objectives** of regulation to centre around three main purposes:

1. Improving the performance of regulated organisations (*by encouraging reflection and self-evaluation from the regulated organisation and positive guidance and encouragement from the regulator in order to encourage the service to achieve legal standards and better practice*),
2. Making organisations more accountable for what they do,
3. Providing information about regulated organisations that others can use in making decisions.

While I am in agreement with the broad sentiment of these 3 main objectives I think it is necessary to be more specific. In order to develop further specificity it is useful to add a collaborative element to objective 1, ensuring that both the regulatory organisation and the provider cooperate rather than developing a frictional relationship (*see additional italics in purpose and objectives*). This places emphasis on service improvement coming from the service provider, creating a situation in which responsibility for quality rests with the provider rather than the regulator. This creates a subtle but important distinction in accountability between regulator and provider, by tipping the balance of accountability toward the provider.

Shifting this balance has a two-fold effect. First, it raises the esteem of the registered manager and places faith in their professional ability. In order to be a registered manager an individual must hold a minimum of a level 3 National Vocational Qualification (NVQ) (or at least be in the process of completing) (Department of Health 2001). By emphasising the professionalism of the managerial position the belief is that the job will attract capable and skilled people, who have to be abreast of current standards and best practice and are capable of running a modern care home. The regulator can then be confident that the manager will be responsible for running a good quality home and because their professional reputation depends on the performance of their service.

Second, a shift in responsibility reduces the ‘policing’ requirement of the regulator, freeing it to work in a more positive manner at the forefront of innovative quality development. Inspectors are free to engage with service providers to cooperatively develop quality, rather than fostering an antagonistic police / offender relationship where the regulator is (*perceived to be*) looking to catch the provider out. In the context of social care regulation I would also add two subsequent objectives:

1. Maintaining minimum standards of safety for both service users and staff,
2. Encouraging involvement of service user groups in decision-making in social services, regulatory organisations and social care providers.

It must be acknowledged that these regulatory purposes can often conflict, forcing the regulator to prioritise one purpose over others (Walshe and Boyd 2005). This dilemma places an emphasis both on the professionalism (technical and tacit knowledge) of the regulator and the relationship of the regulator with the provider. Professionalism of the regulator is important because it encompasses both the technical and tacit knowledge required to do the job effectively. Technical knowledge represents the regulators knowledge of the rules and regulations. Tacit knowledge is the wisdom and experience of the regulator and their ability to use their professional experience to make judgements over what represents particular importance in specific cases; this helps to prioritise, and demonstrates the need for well trained and qualified regulators.

The relationship between the regulator and provider is important because it may be necessary for the regulator to determine and understand why priorities are made. This requires the manager to have both the professional ability to determine priorities and to justify to the regulator, using appropriate evidence, why a particular decision has been made or course of action taken, possibly at the expense of other areas.

2. Regulatory body or agency

The **regulatory body or agency** – its nature, legal form, powers, funding and governance - are crucial to any form of regulation. A regulatory agency can take the form of a statutory body with clearly defined legal powers and a remit entrenched in law, or it can be voluntary, working from a mandate stipulated by the organisations it regulates. Depending on its structure the body could be funded by government, or through contributions from regulated organisations. Decisions concerning the body's legal form and funding determine whether it is held accountable by elected officials in government or a governance structure determined by funders and key stakeholders, independent of government (Walshe and Boyd 2005).

With respect to social care, a system of privately operated regulation, with a mandate stipulated by the organisations it regulates and compliance checked by providers

themselves is not acceptable for a service which deals with individuals' safety and well-being; it lacks legitimacy in the eyes of those who use the service, and is often self serving. Historical instances of mis-treatment and abuse clearly demonstrate the need for publicly accountable regulation. In this context a proactive situation in which an independent, publicly accountable regulator works with service providers and users to co-operate in defining standards of practice and implements these standards in a transparent, effective manner through inspection is the optimum method of regulation for a service which deals with the safety and well-being of a vulnerable section of the population.

3. Range, nature and scope of regulated organisations and activities

The **range, nature and scope of regulated organisations and activities** consists of factors such as size, composition (homogeneity or heterogeneity) of regulated organisations, and extent of scope both horizontally (across organisations) and vertically (within organisations) (Walshe and Boyd 2005).

Within social care the scope of regulation needs to be wide and focused on all aspects of care. Reports from across the world in the 1980s demonstrated that regulation has to first and foremost be interested in resident / patient care matters. The focus must be on outcomes of care, rather than inputs into service provision. Changes to the ethos and scope of regulation were recommended by the Giles Report (so called as the Senate Select Committee was chair by Senator Patricia Giles) in Australia (1985) and the Homes Are for Living In report by the Department for Health in the UK (1989c); reports which are reflective of a change in thinking regarding the composition of social care regulatory agencies. These reports demonstrated that it was no longer good enough to simply look at traditional measures of quality of care, such as size of rooms. Regulators must also to look at quality of life issues, which may not be demonstrated by simple objective indicators.

In order to be effective at maintaining safety and quality of life the regulatory agency has to be large, in both size and scope. Social care providers offer a diverse range of services, so they require a flexible and multi-faceted regulatory organisation that can understand the characteristics of the particular service they provide. Social care encompasses: nursing care homes, residential personal care homes (for the elderly, adults with learning disabilities and children) and domiciliary care. Although these services appear heterogeneous they all have the same fundamental responsibilities of providing care that offers users two

fundamental rights: safety and a good quality of life. The heterogeneity of social care services means that the regulatory body also has to be relatively heterogeneous and have the scope to regulate across the various organisations and types of services. It must also have the scope to infiltrate vertically within an organisation to gain a heuristic understanding of service practices. This offers a vantage from which to locate and eliminate bad practice and offer useful, constructive advice to help a service provider improve.

4. Regulatory regime

‘The **regulatory regime** is the activities and process which make up the work of the regulator’ (Walshe and Boyd 2005: 4). It is usually divided into three areas – *direction, detection and enforcement* – and is shaped by the regulatory agency’s philosophy and remit, which in turn is determined by the legislation set out by government and the interpretation of this by the regulator. The regime is also dependent on how the regulator interprets the regulated organisation and how it views the relationship between the two. The regulated organisations can be seen as compliers, willing to cooperate and take advice in a productive manner or deceivers who act amorally by nature and attempt to avoid and subvert the regulatory process through deception and calculated non-cooperation. The way the regulators and the providers interpret the regulatory regime determines their approach to the process (Walshe and Boyd 2005).

Consultation of services users within social care has shown that the *direction* of the regulator must be orientated towards maintaining and improving safety and quality of service, with particular attention to the quality of life of service users (see Department of Health 2005). Comparative analysis of European models of social care provision shows that although there are often significant differences in provision across countries this is often the result of political and policy limitations, driven by finite resources. Despite the limitations on delivery of service there is still a consensus that there should be clear minimum levels of care (Leichsenring 2004).

Detection involves both a ‘policing’ role to keep providers in check, but also a ‘cooperative’ role to encourage service providers to self-assess and be constantly seeking improvement. How the regulator balances this duality can have an effect on both the role and scope of the regulator, in terms of how it operates, and the relationship of the regulator

with the provider. A regulatory system that encourages a self-critical role for the provider, and a regulator that works with the service to drive improvement is very different to one that fosters an antagonistic relationship of police and perpetrator. It is inevitable that the relationship is never this clear cut, but the ethos and direction of the regulator can have a huge influence on the type of regulatory system that evolves.

Enforcement can be achieved both directly and indirectly. At the extreme, direct enforcement can be asserted through closure notices, but only after a lengthy engagement with a service to attempt to rectify the issue and the due process of legal action. More often enforcement is conducted through the administering of 'requirements or recommendations'. These stipulations indicate to a service that they need to improve a particular aspect of their service, sometimes within a certain time frame. A second, indirect method of *enforcement* can be provided by a rating system, which is made public and allows the public to see how well a service is performing. People are then free to choose which particular services they want to use, providing an incentive for services to maintain quality, or face a bad reputation and people opting to use and crucially pay for other services.

In order to mitigate the demand this new choice agenda places on the autonomy of the individual, to make the right choice when deciding upon a particular service, the government has promulgated that individuals should have the 'best possible' information to make a choice of service. A system of regulation has been developed that places information in the hands of the public. The key to achieving this goal in social care has been to implement a rigorous and transparent inspection regime, with outcome information readily available to the public. This process of inspection and dissemination reflects a wider movement (also in education, health) in public service provision, toward 'new managerialism' (Kirkpatrick and Lucio 1995) and what Hood et al (1999b) argue is the creation of the regulatory state.

THE DEVELOPMENT OF THE INSPECTION PROCESS: PATH TO AN OUTCOMES APPROACH

There is a variety of legislation, beginning in 1948, that has shaped both the way that residential care has developed in England and how local authorities have a primary role in providing and financing residential social care services.

The **National Assistance Act 1948**, which was updated in 1992 with the **Choice of Accommodation Directions (1992)**, and then further updated in 2001 with the **National Assistance (Additional Payments and Assessment of Resources) (Amendment) (England) Regulations 2001** stipulates in sections 21 and 47 that local authorities have a duty to provide accommodation for people in need of support and care ‘otherwise not available to them’. It sets out what individuals should expect from the council that is responsible for funding their care, subject to the individual's means, when arranging a care home place for them. Any individual with less than £13000 of assets is entitled to safe and secure accommodation and care paid for by their local authority. If an individual has assets between £13000 and £21500 then they are expected to make some contribution towards the cost of their care. Anyone with more than £21500 of assets is expected to make the full contribution towards the cost of their care until their assets fall below that threshold; assets include both savings and property (CSCI 2007b). Accommodation should also be allocated based on the individual’s preference, providing their assessed needs will be met and the cost is not over the ‘usual cost’ – i.e. what the council would expect to pay for accommodation based on the assessed needs of the individual. It also stipulates that individuals can choose to pay a ‘top-up’, to make up the difference between the fees and the price the local authority will pay in order to move into somewhere of their choosing.

There was a long gap in legislation to the **NHS and Community Care Act 1990**, which essentially tried to shift local authority practice from resource-led placing, i.e. fitting people into services already available, to needs led placing, in which the individual’s needs are assessed by a social worker and are given the option of a range of services based on a decision (jointly arrived at between the social worker and the service users) about what service(s) would best fulfil these needs. The Act heralded the shift towards a care planning process based around the needs of the person, which sets out to jointly determine an individual’s needs with the full involvement of the service users. From April 1991 local authorities were made responsible, with collaboration with necessary health care professionals, for assessing the needs of any individual who requested public support for

their social care. Together the social worker and the service user decide on appropriate services to meet their needs and then monitor these services by measuring the outcomes.

The 1990 Act also introduced the need to develop a mixed economy of care in which the local authority will play a major role in stimulating the growth of non-statutory, independent service providers that meet the required standards of care (Department of Health 1989b). This was justified because it was thought to be the most cost-effective way to develop new and innovative service provision, free from the expensive, bureaucracy laden local authority 'in-house' provision of earlier decades. The role of the service users as a 'partner' in their care provision was not explicitly stated in the 1990 Act and its associated documentation, this came later, but it was definitely implicit in the format of their care assessment.

In terms of regulation the 1990 Act was crucial because the role of Local Authorities was redefined: to become purchasers rather than providers of care. Second, any remaining Local Authority run homes were to move from their position immune from systematic inspection, to be scrutinised by the regulatory process; the shift from provision to regulation represented a paradigmatic shift in welfare provision. To ensure greater authority and legitimacy, the one hundred and seven Inspection Units in England were given semi-autonomous status, but kept within the social services departments. Lay assessors were also introduced into the inspection process and inspection reports were made public documents for the first time. The foundations of stakeholder involvement were also developed by the creation of Advisory Committees to work alongside each Inspection Unit, crucially these included representatives of providers but not service users, and so only represented the first step of modernisation (Day, et al. 1996).

According to Day et al (1996) 'the new inspection units set up in the 1990s have had to invent themselves' (Day, et al. 1996: 2). Their new duties included familiar responsibilities in current regulation, such as registration of all new and existing care homes and day care facilities. However, although the scope of the regulatory framework was increased dramatically by the inception of the 1990 NHS and Community Care Act the requirements and regulations that the new bodies had to enforce were still defined by the 1984 Registered Homes Act. In order to respond to the new changes the 1984 act was simply reviewed and translated into regulations by the SSI, rather than there being a new set of

legislated regulations to compliment the advent of a new inspection process. This gap in legislation meant that regulations were left to be defined by the non-elected process administrators – further evidence of the administrator prerogative. However, because of the limited confines within which they could interpret the 1984 Act the SSI were placed in a policy straight jacket, unable to affect the same wide ranging changes to the process of inspection as was made to the structure of the inspection units.

The ambiguous and poorly conceived language of the 1984 Act also meant that national requirements were set out in general terms of ‘adequacy’ and ‘sufficiency’ as opposed to the more stringent and ambitious language of ‘requirements’ and ‘national minimum standards’ that is used today. The generalness of the terms and ambiguity of the Act also required the regulatory authorities to beef up and expand upon the local guidance to providers, and the conditions of registration, which gave a greater professional role to administrators of the inspection process, but sacrificed consistency and ultimately accountability by placing a large proportion of the regulatory decision-making in the hands of local level non-elected public servants (Day, et al. 1996). The regulatory system at this point was further fragmented, because local authorities were responsible for registering and inspecting residential care homes and health authorities responsible for nursing homes. A lack of attention to the regulatory mechanisms in the early 1990s further suggests that the Conservative government was preoccupied with marketisation and felt that this would root out poor providers, eliminating the need for lengthy, interfering government legislation. I have argued that this proved to be misguided and by neglecting regulatory policy in the 1980s and 1990s the Conservative government only served to further fracture the social care system and reify the inappropriateness of marketisation to develop and improve provision.

Fragmentation and ambiguity continued throughout the 1990s until the Labour government published the 1998 White Paper *Modernising Social Services* (1998). Regulatory structures before the White Paper were regarded as bureaucratic and snapshot, doing little more than maintaining minimum standards of care (Reed, et al. 1999). This contrasted with the prevailing political impetus of the New Labour Government which focused on evidence from quality assurance processes outside of social care that demonstrated the benefit of engaging with service users and soliciting their views. Although it addresses social

services as a whole the paper was devised partly in response to three main criticisms of regulation:

1. Standards were inconsistent across the country
2. Local authority inspection units are insufficiently independent
3. The division between health and social care is an artificial one

(Burgner 1996)

The White Paper outlined plans for the development of eight regional Commissions for Care Standards in England, which would alleviate fragmentation by bringing the regulation of all residential, domiciliary and nursing home care for both adults and children under one new ‘joined-up’ authority, working to new national standards.

In response to the impetus of new legislation the Department of Health commissioned the Centre for Policy on Ageing to devise a set of *National Required Standards* to be enforced by the National Care Standards Commission (NCSC). The draft of these standards were submitted in 1999 and the final version was published in 2001 by Department of Health as ‘*Care Homes for Older People: National Minimum Standards*’ (2001b). These standards formed the basis for inspection, dictating the benchmarks to which providers of social care had to conform. They were devised through consultation of stakeholders and represented a change in tact from preceding governments, towards a more inclusive, ‘bottom-up’ legislative process.

Legislation for these changes occurred in the **Care Standards Act 2000**, which replaced the by now debunked and grossly inefficient Registered Home Act 1984. However, instead of eight regional commissions, as envisaged in the Modernising Social Services White Paper, the National Care Standards Commission (NCSC) took control of regulation in April 2002.

With the implementation of this new act the vague, unenforceable standards, which led to a lot of confusion were replaced by NMS that specified exact criteria that had to be met in order to adhere to the standard. To remove the ambiguity and inconsistency caused by uncoordinated, local regulation the 2000 Act introduced the NCSC to regulate services nationally.

NMS are not set out in legislation and are therefore not enforceable in law, but they do set out the terms and conditions of what the regulator deems to be the minimum level of care a service must provide. The regulator, working as an independent public service body, must decide whether services meet **The Care Home Regulations 2001**, which are mandatory and to do this takes into account NMS. However, these standards do not represent the only regulations and a care home can still be deemed as not meeting The Care Homes Regulations 2001 even if it is meeting all or most of the NMS. The NMS ‘focus on achievable outcomes for service users’ (Department of Health 2001b: 9) and measure the impact the services provided by the home have on these outcomes. After significant consultation with service users the Department of Health grouped the NMS into seven outcome groups, which correspond to the most important aspect of people’s lives highlighted during the consultation:

- Choice of home
- Health and personal care
- Daily life and social activities
- Complaints and protection
- Environment
- Staffing
- Management and administration (Department of Health 2001b)

These seven areas cover all 38 NMS, which each fall under one of the general headings. Each of the seven outcome areas are justified by a statement of good practice that sets out how these outcomes should be met. The regulations then state that evidence to assess whether the 38 standards are being met should be sought from:

- Discussions with service users, families and friends, staff and managers and others
- Observation of daily life in the home
- Scrutiny of written policies, procedures and records

(Department of Health 2001b)

An assessment of whether the home has sufficiently met the 38 NMS combined with a wider assessment of whether the home has met The Care Homes Regulations Act 2001 determines whether a care home service is providing sufficient quality under the Care Standards Act 2000. These decisions are also made within the wider context of

government policy around whether service users are having their independence and choice promoted.

In April 2004, as a result of the enactment of the Health and Social Care (Community Health and Standards) Act 2003, the NCSC ceased to exist and the CSCI took over responsibilities for regulating care services in England. The CSCI was created to bring together all aspects of inspection and regulation under one umbrella and create a joined up form of regulation. The Act brought together the work of three previously independent bodies:

- The Social Services Inspectorate (SSI)
- SSI / Audit Commission Joint Review Team
- The National Care Standards Commission (NCSC)

This created a commission with a much wider remit than its predecessors, forming an organisation with an overview of the whole of social care; focusing on the five main roles of a regulator: inspection, registration, development, complaints and enforcement. As well as the inception of this new regulatory body the Health and Social Care Act 2001 also explicitly states the CSCI has two main functions under section 76:

(1) The CSCI has the general function of encouraging improvement in the provision of English local authority social services.

(2) In exercising its functions under subsection (1) and sections 77 to 81 in relation to the provision of such services the CSCI shall be concerned in particular with—

- (a) the availability of, and access to, the services;
- (b) the quality and effectiveness of the services;
- (c) the management of the services;
- (d) the economy and efficiency of their provision and their value for money;
- (e) the availability and quality of information provided to the public about the services;
- (f) the need to safeguard and promote the rights and welfare of children; and

(g) the effectiveness of measures taken by local authorities for the purpose specified in paragraph (f).

(Health and Social Care (Community Health and Standards) Act 2003)

The Act was intended to increase the role of the regulator to focus on quality outcomes for the service user, with particular attention to their choice and empowerment. There is also provision under the Act that the CSCI should, when asked by the Secretary of State, give advice on matters relating to the provision of registered social care services in England.

The model of UK regulation

Today the UK regulatory framework is structured using the public / proactive system (see Table 1). The ‘regulatory state’ functions in two ways: first, it determines, through consultation, a set of minimum standards for a particular sector of society (e.g. social care, education). An assessment of quality is used, based on the set of standards devised by an independent body, legislated or otherwise. These rules aim to primarily protect the safety of users, and allow them the opportunity to live a dignified life, free from marginalisation, by ensuring the services they require meet social, cultural and emotional needs. In this role the state fulfils a paternalistic function – consulting upon and then determining an acceptable level of provision for a public service body.

Secondly, regulation has an equally important goal of driving improvement, a goal that can be achieved by two means. The first runs interdependently with the choice agenda and is based on the assumption that if an individual is given a choice of service and is given sufficient information to make that choice, because they will only choose services of the highest quality all service will be forced to ‘raise their game’ and improve the quality of their provision. A choice agenda provides key regulatory quality assurance mechanism, if services fail to live up to expected standards they will face being driven out of the market. This belief draws on aspects of free market economics (albeit only small aspects, within the context of government led regulation), whereby poorly performing services are pushed out of the market, as they cannot compete with better services. Doing this removes a large proportion of accountability for the quality of services away from the state and places it firmly in the arms of the consumer – they are being given information on standards and quality of service, so if people, either individually or collectively, end up with poor quality services it is because they choose to, rather than because the state offers poor provision.

In this theoretical context I now present the findings of a systematic review into the effectiveness of inspection in residential social care.

CHAPTER 2: A SYSTEMATIC REVIEW OF THE IMPACTS OF INSPECTION AND REGULATION ON OLDER PERSONS' RESIDENTIAL SOCIAL CARE

Effective Inspection: Why conduct a Systematic Review (SR)?

There is little existing evidence to suggest what constitutes effective inspection in social care, or whether effective inspection promotes factors which older people claim improve their lives. It is unclear what impact inspection has on outcomes of social care or what outcomes designate effective inspection. There are various ways the inspection process could be judged to improve quality of care, including:

- Improving care homes' performances against a set of measurable standards
- Improving the lives of residents as measured, for example, by an increase in participation, or increase in measured objective well-being.
- Inducing an increase in staffing levels, which research in both Australia and the United States has shown corresponds directly with improved care (Braithwaite 2001; Harrington 2001).
- Impacting on whether care is purchased from a particular home. As yet there is little international work on establishing links between care home performance and purchasing of residential care services, either by individuals or by government authorities (Harrington 2001).

It is unclear whether inspection works in all instances, in all older persons' care homes, or whether it has a greater effect on some homes compared to others and particular outcomes over others. This protocol is driven by the necessity to improve the knowledge base of social care inspection and inform policy making by facilitating decision-making that is well informed by evidence.

A lack of existing evidence

The CSCI has very little information on the efficacy of the inspection process, which suggests there is a dearth of accessible research. This apparent lack of impact research is not just limited to social care inspection. There has been little policy research done in the

UK on outcomes research *per se*, with the Department of Health instead focusing much of their work on monitoring the impact of legislation (Macdonald 1999). The rhetoric of governments, built on or influenced by the Third Way pragmatism of ‘what counts is what works’ and the subsequent belief that policies should be ‘evidence based’ is left wanting when there is no systematic body of evidence on the benefit and costs of inspection and regulatory regimes (see Boyne, et al. 2002; Hood, et al. 2000).

The apparent lack of research on effectiveness seems to represent a certain level of scepticism social care researchers have towards the epistemology of evidence-based policy making and its affiliation to health based research. However, in order to be accountable, social care regulatory bodies, as regulators of government policy (or at the very least social justice), need to reflect on the efficacy of their work and establish a knowledge base from which they can begin to assess their performance. What this review aims to achieve is to begin to build a map of international evidence on the efficacy of social care inspection and help to inform evidence based decision making in the social care sector by systematically searching for, and analysing all relevant studies in the field of inspection and regulation of older people.

There is also a need to build upon questions of efficacy and determine what makes inspection more or less effective. Within the UK there has been a paradigmatic shift to place service users, not just social care professionals, at the forefront of improving social care. In light of this inclusive direction and in concomitance with considering the impact and effect of inspection, it is necessary to examine why inspection has an effect (either negative or positive) on the users of social care and understand how the inspection process directly effects the individuals it aims to serve.

Objectives

The aim of this review was two-fold and it was conducted in two separate parts:

- A. **Effectiveness question:** Assess evidence for the efficacy or otherwise of the regulation and inspection process to improve living conditions and well-being in older people (over 65) living in residential care

B. Process question: In what conditions are inspection and regulation more or less effective? How do service users view the inspection process?

In order to answer question A I used the best available evidence from well-designed and explicit trials, whether randomised or not.

Question A locates studies which show what works but which do not tell us why or how they work therefore I propose that the second part of this review will look at process issues. Question B will be answered using data from qualitative research and other types of process research and evaluations that reflect key contextual and implementation issues of regulation and inspection.

PROTOCOL

For a full protocol please see Appendix 1.

SYSTEMATIC REVIEW FINDINGS

Mapping the research

The search spanned 21 websites or databases and initially located 12386 articles, books or conference papers (for the table breakdown of each database sources see appendix 2). From this initial number 12308 were eliminated based on title or abstract², leaving me with 78 full text articles. For an overview of this process see Appendix 1.

Full text versions of the 78 articles were retrieved and examined to determine whether they fit the inclusion criteria of the Systematic Review. The results were as follows:

Excluded articles

For table of all articles excluded after the full text stage see tables at end of Appendix 1.

² Most databases gave an abstract as well as title with their output. For those databases which only gave a title I ordered full text articles for any output which I could not make a decision to eliminate based on title alone. However, in order to be consistent, these were only registered as full-text articles in the search table, if I could not eliminate them after reading the abstract.

There were 69 articles excluded after looking at the full text.

Articles I could not locate, or retrieve

I could not get access to 2 research articles:

1. Davies, B. (1999) *The Regulation and Deregulation of Social Care*, a PhD Thesis.
Not available through The British Library Document Supply Centre.

There were 6 studies which fit the inclusion criteria of the SR and which are included in the analysis:

Table 3: Included articles for process question

| Author | Title | Date Published | Publication | Database / web portal |
|------------------------------------|--|----------------|--|----------------------------|
| Sinclair, I. and Gibbs, I. | Consistency: a pre-requisite for inspecting old people's homes? | 1992 | British Journal of Social Work | CSA illumnia |
| Sinclair, I. and Gibbs, I. | Residential Care for Elderly People: The correlates of Quality | 1992 | Ageing and Society | Social Policy and Practice |
| Fleishman, R. et al | Improving the quality of institutional care on urinary incontinence among the elderly: a challenge for government regulation | 1999 | International Journal of Health Care Quality Assurance | CSA illumnia |
| Counsel and Care | Under Inspection | 1995 | Counsel and Care report | Ovid |
| Redmayne, S. | Spotlight on Homes for the Elderly: an analysis of inspection reports on care homes for the elderly | 1995 | Bath Social Policy Papers | Social Care Online |
| Day, P. Klein, R. and Redmayne, S. | Why Regulate? Regulating residential Care for elderly people | 1996 | Policy Press and Joseph Rowntree Foundation | Social Policy and Practice |

Effectiveness studies

The limited scope of research design in many studies, coupled with the limited information provided in published accounts (journal articles, reports), means that it is difficult to establish an evidence base for the effectiveness of inspection in social care. In order to best assess the effectiveness of inspection it is necessary to focus on the outcomes of the process, to determine whether inspection delivers the best consequences for social care

service users. When examining the impact of inspection on social care services there are six main outcome areas:

1. Resident's reaction to the inspection
2. Stimulation – new activities undertaken by residents
3. Behaviour change of residents
4. Behaviour changes of staff – change in attitudes or perceptions towards service users
5. Changes in organisational practice – relates to changes in service delivery
6. Benefits to users and carers – improvements in well-being and quality of life for people who use the service and staff.

It is appropriate to conceptualise inspection both as a motivator for change in service delivery and as a causal determinant of changes in resident and staff behaviour. In acting as a motivator inspection provides a 'check mechanism' to keep the service 'on its toes'; the manager is aware that there could be an inspection at any time (theoretically). The second function of inspection is to provide a 'change mechanism', which will pick up on areas in which the service is failing to attain standards. Inspectors will alert the service to this situation and demand that something is done to rectify the problem.

By looking at outcomes using these two mechanisms it focuses attention on possible different levels of inspection effectiveness and places a focus on service-user views; determining whether inspection has had a positive outcome on their lives.

This review located **0** studies of effectiveness that reach the methodological standards stipulated in the guidelines developed in the protocol for this review.

This SR demonstrates a lacuna in the field of research that examines the appropriateness of current arguments about the effectiveness of inspection by attempting to ascertain whether it is effective in practice. Without any literature examining how effective inspection is at safeguarding older people, assuring their needs are met and their choices respected, or determining if the regulation is cost-effective, it becomes increasingly difficult to judge whether inspection is achieving its purpose or whether it could be carried out more effectively.

There is little dispute that inspection of older persons' residential care is necessary, but at present there is no research, that meets appropriate scientific methodological criteria, to support its success. There is a plethora of anecdotal evidence, from residents, family, staff and others involved in residential care, to suggest that this is the case, but in a society increasingly occupied with targets and evidence, anecdotes are not enough to influence policy decision-making, unless they are collected in a systematic and unbiased way, in a manner that adheres to conventions of methodological rigour.

Process Studies

Evaluation of the process of inspection and regulation of older persons' residential social care provides a context to understand the results of policy-making more fully. It is designed to describe what goes on, rather than to establish whether or not something works. Studies on the process of an intervention may lead to suggestions for improvements, especially if the intervention is to be rolled out on a larger scale. As Kavanagh et al (2006) explain:

'Process issues make a vital, and sometimes underestimated, contribution to the effectiveness and sustainability of a programme. This is particularly the case where an intervention is designed for mainstream use in complex and busy working environments such as schools and colleges, youth clubs, or health care settings.'

(Kavanagh, et al. 2006: 40)

This review found 6 studies that met the inclusion criteria of objective B.

Synthesis

There were 0 studies which fulfilled the inclusion criteria of objective A. Therefore I will only discuss the synthesis of studies included to answer the objective B question.

Processing Objective B studies

The high volume of studies in systematic reviews means that on the whole quality appraisal is conducted separately to data extraction. As recommended by Fisher, et al. (2006) the synthesis was conducted with reference to information recorded on the data extraction forms (see Appendix 1). These forms were constructed from a template

designed to allow the included studies to be analysed and presented in an accessible form. Using these records greatly expedited the writing process because data and analysis could be drawn from the pre-compiled record and incorporated into the review. Keeping a record for each of the included studies also provides a useful way of organising included studies, which when over 12000 returned across the databases, can be a difficult task. If I was unsure about a particular theme or idea I occasionally referred back to the individual research papers for clarification.

As there was only one person conducting the review there was no scope for an inter-rater reliability test.

Rationale for synthesising qualitative research

Estabrooks et al (2004) claim that analysis and synthesis of an ‘aggregation’ of qualitative studies can contribute more powerfully to theory-building than any single study. Synthesis of evidence in this way allows for the development of larger narratives and more generalisable theories. In this way it can overcome the common problem of isolation, often associated with qualitative research, allowing for the construction of cross-study themes and more robust analytical categories (Dixon-Woods, et al. 2004).

The pooling of qualitative studies also allows for the optimum use of primary data. As Thorne (1994) asserts, some questions can only be answered using a range of data sources, especially when occurrences are too rare to be identified by a single study, e.g. the use of observation may uncover issues not picked up by interview studies, such as instances of incompetence. A synthesis also generates a larger sample of data that can provide more significant explanations than one study alone (Sherwood 1999). To combine the data of all available studies is incredibly useful for research on vulnerable or hard to reach groups because it maximises the available evidence from an area which might be very sparse on research. In conjunction with this Campbell et al (2003) found when they investigated seven qualitative studies on patients’ experiences of diabetes, that not one referred to the other. A problem with obvious connotations in fields where there is already a dearth of research. As systematic search and synthesis allows for well-informed conclusions and paves the way for research that provides continuity and builds upon existing data.

Unlike quantitative research, methods of synthesising qualitative forms of data have developed slowly and the optimum method is still contested (Dixon-Woods et al 2004). Work such as that by Dixon-Woods and Fitzpatrick (2001) concede that analysing qualitative research is still a matter for debate and they demonstrate the need for further research and development in this area.

The studies were analysed from the data extraction records using a non-computer based coding scheme. The analysis was 'interpretive' rather than 'integrative' (Noblit and Hare 1988). Integrative approaches are more common with quantitative data and work on the assumption that pooling similar data that examines the same variables will enhance the reliability of the review. The studies included in this review, looking at the impact of the inspection process on the lives of residents, were varied and all looked at different aspects of the inspection process. This made it impossible to quantify the qualitative data to conduct 'integrative' analysis, nor would it have been appropriate considering the types of studies the search uncovered.

An interpretive synthesis focuses on data that provides concepts, the theories which may integrate those concepts and then check for the consistency of them in relation to all of the available data. The synthesis will avoid specifying the concepts in advance of the study and rather than being about just an aggregate, or summary, of the data analysis will also lead to ideas, or concepts. It must be pointed out that an interpretative study still has to be 'grounded' in the data from the studies synthesised (Dixon-Woods et al 2004).

Methodological Critique

Table 4: Examining the methodological quality of the included studies

| Study | Sample | Data Collection | Data Analysis | Generalisability | Implications for policy / practice |
|---|---|--|---|---|--|
| <p>Gibbs and Sinclair (1992a)</p> <p>Consistency: a pre-requisite for inspecting old people's homes?</p> | <p>48 homes (16 LA, 24 private, 8 voluntary) across 5 local authorities (2 boroughs and 2 councils) in different regions of England were used in the study.</p> <p>Non-random allocation, each Local Authority asked to select an agreed number of homes from the local authority</p> | <p>Two pre-existing instruments were adapted to measure quality. The tools used six basic values, which were deemed to contribute to the quality of a home: privacy, dignity, independence, choice, rights and fulfilment. Statements about the 'good' home became criteria against which professional judgements can be made about the home in question. Checklists were consulted with staff from local authorities and SSI.</p> <p>The homes were visited in two stages – stage 1 involved a visit to each of the 48 homes from a member of staff from the corresponding LA. At stage</p> | <p>The authors examined the reliability of the rating system by cross-tabulating ratings made on the first visit with those made on the second to see how far the inspectors agreed. The data were analysed using <i>kappa statistics (measure of degree of non-random agreement between observers and/or measurements of a specific categorical variable)</i> – a measure of agreement which allows for both the fact that inspectors may plump for particular ratings and reflects the degree to which their actual agreement exceeds that which could be expected on this basis.</p> | <p>Not sufficient for results to be generalised, but justified as a test of a tool which might act as an aid to inspection.</p> <p>The authors hope their results would lead to a further larger study</p> <p>There were methodological problems with Gibbs' and Sinclair's study. To develop any form of consistency for judgements using items developed from the HAFLI</p> | <p>Potential to develop quality checklist for inspectors</p> <p>To develop innovative methods of inspecting older person's residential homes. Provide 'aide memoire' for inspectors, reminding them to cover certain areas, rather than creating an instrument yielding a score on which homes will pass or fail. The authors also recommend further research into 'reliable and hard' performance</p> |

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| | | <p>2, 4-6 weeks later homes were re-visited by a different inspector (in 50 % of homes this was a different inspector from the same LA, in the other half this was a member of staff from SSI). The visits lasted between 6h 15 mins and 6h 30 mins each.</p> <p>No mention of ethical approval being obtained. No mention of ethical considerations. No mention of informed consent from homes, but inspectors have jurisdiction to visit.</p> | <p>To develop any form of consistency for judgements using items developed from the HAFLI³ checklist, they could only utilise 12 items, which inevitably led to deficiencies in the areas of service provision inspected.</p> <p>The desire to avoid bias in the second stage of analysis also meant that the statistical test for efficiency was only carried out on a very small number of homes, a number not sufficient enough to produce generalisable results.</p> <p>Adequate evidence is provided to support analysis, which acknowledges the limitations of the checklist. They do not make robust statistical claims, nor from these</p> | <p>checklist, they could only utilise 12 items, which inevitably led to deficiencies in the areas of service provision inspected. The desire to avoid bias in the second stage of analysis also meant that the statistical test for efficiency was only carried out on a very small number of homes, a number not sufficient enough to produce generalisable results.</p> | <p>indicators; tools for identifying opinions of residents and relatives, and a procedure to encourage 'whistle-blowing'.</p> |
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| | | | <p>claims do they infer generalisation of the tool. The checklist is advocated as a helpful tool to be used alongside other inspection measures.</p> <p>The aim of the study was to provide a trial for a new form of inspection checklist and determine whether a statistically significant level of agreement between inspectors using the checklist was possible. The aim was to break new ground and set up further research. There was no inter-rater reliability, but this is justified because the aim of this research was to develop a 'heuristic device' to help make quality judgements and in practice inspection teams do not have the time or resources to perform inter-observer reliability.</p> | | |
| Gibbs and | 48 homes (16 | Two pre-existing | The authors attempted to | Findings suggest | Guidance for local |

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| <p>Sinclair (1992b) Residential Care for Elderly People: The correlates of Quality</p> | <p>LA, 24 private, 8 voluntary) across 5 local authorities (2 boroughs and 2 councils) in different regions of England were used in the study.</p> <p>Non-random allocation, each Local Authority asked to select an agreed number of homes from the local authority</p> | <p>instruments were adapted to measure quality. The tools used six basic values, which were deemed to contribute to the quality of a home: privacy, dignity, independence, choice, rights and fulfilment. Statements about the ‘good’ home became criteria against which professional judgements can be made about the home in question. Checklists were consulted with staff from local authorities and SSI.</p> <p>The homes were visited in two stages – stage 1 involved a visit to each of the 48 homes from a member of staff from the corresponding LA. At stage 2, 4-6 weeks later homes were re-visited by a different inspector (in half homes this was a different inspector from the same LA, in the other half this was a member of staff from</p> | <p>examine the quality of care across different dimensions, which could then influence an overall quality of care. In examining the correlates of their measure of quality they grouped their hypotheses under four main headings: Head of Home; Staffing; Resident Dependency; Buildings</p> <p>They also examined the consistency of inspector’s judgements when using the checklists they had developed in conjunction with HAFLI and Bradshaw.</p> | <p>hypotheses rather than prove conclusions.</p> <p>Findings appear to be consistent with professional opinion.</p> <p>There were methodological problems with Gibbs’ and Sinclair’s study. To develop any form of consistency for judgements using items developed from the HAFLI checklist, they could only utilise 12 items, which inevitably led to deficiencies in the areas of service provision inspected. The desire to avoid bias in the second</p> | <p>authorities and home proprietors to improve the work they do. Guidance for managers to look at staff training and other practice issues.</p> |
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| | | SSI). The visits lasted between 6h 15 mins and 6h 30 mins hours each. No mention of ethical approval being obtained. No mention of ethical considerations. No mentioned of informed consent from homes, but inspectors have jurisdiction to visit. | | stage of analysis also meant that the statistical test for efficiency was only carried out on a very small number of homes, a number not sufficient enough to produce generalisable results. | |
| Fleishman, R. Heilbrun, G. et al. (1999) Improving the quality of institutional care on urinary incontinence among the elderly: a challenge for government regulation | Regulatory data from The Service for the Aged shows 14406 residents in 196 residential care homes. Further in-depth analysis was then conducted on 48 homes that underwent at least 4 regulatory cycles between 1987 and 1996 | Each institution completes a form for each resident ever year – which includes a number of questions on urinary incontinence (UI) and assistance needed for using the toilet. 10 residents are randomly chosen from each institution to be interviewed by a social worker or nurse about their care, including toilet habits and urinary incontinence. The social worker and nurse also reviewed resident records and perform observation of the | Summary of indices of quality, the percentage of institutions with deficient items and those showing change. The study looks at the correlation between UI and other related functional conditions. There were calculations of UI prevalence in residential homes and by ownership, a description of functional status, the percentage of institutions with deficient items, a | The study used data from nearly all residents in care homes in Israel for a summary of the prevalence of UI in care homes in Israel and the regression looking at ‘average rate of deficiencies in the UI care process’. This data is very generalisable. The regression has a p value <0.000 so is | The study shows that regulation does improve the overall performance of care homes in relation to urinary incontinence. However, structural changes required to improve UI deficiencies (e.g. number of physicians per bed, number of nursing aides per bed) did |

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| | <p>were subject to deeper analysis. (The study also looks at data from 8278 patients in 159 hospitals, but this is reported separately). The residential population includes approx. 7 % nursing patients, which although breaks Israeli rules is allowed on small scale for social reasons (e.g. near to spouse). <i>This is acceptable in terms of my cut off of no more than 15 % of population not older people residential.</i></p> | <p>care processes. They also interview the institution director, 'house mother' and nurse (where applicable).</p> | <p>summary of the indices of quality and a calculation of the rate of change between inspection cycles for the institutions with deficient items. To indicate the quality of care multiple regression is used to explain the variance in the rates of deficiencies through institutional independent variables.</p> <p>Quality of care is evaluated through structure, process and outcome areas.</p> | <p>statistically significant.</p> <p>For the in-depth part of the study examining how regulation affects UI 48 out of approx. 200 total homes in Israel were used.</p> | <p>not improve significantly over the regulatory cycles studied.</p> |
| Day, P. Klein | 11 local | A one year study that | Narrative policy analysis | Good development | Good research into |

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| <p>R. and Redmayne, S. (1996)</p> <p>Why Regulate? Regulating residential Care for elderly people</p> | <p>authority areas of various sizes and settings (e.g. rural, urban, metropolitan), ranging from 50-100 homes within the authority to >1000. 9 Providers were consulted, 6 user groups and 8 other groups (e.g. SSI Kings Fund)</p> <p>There was no specification of inclusion or exclusion criteria.</p> | <p>involved interviewing local authority inspection staff, home providers and users in England. It also made use of existing data (from the Social Services Inspectorate) to examine the performance of inspectorates against government targets and compare the SSI units.</p> <p>Authors claim to begin ‘from a position of agnosticism in the ‘deregulation’ debate.</p> | <p>using policy papers and inspection reports. Analysis of participants’ responses to questions on how they applied and interpreted policies and regulations in practice.</p> <p>Poorly described method. No method section, only very limited information in introduction.</p> <p>Use of existing data from SSI and other forms of evidence (such as DoH statistics, Association of Directors of Social Services survey etc). Use of quotes from interviewees to depict their views on regulation.</p> | <p>of recommendations resulting from analysis of current policy (both positives and deficiencies) and consultation with stakeholders in the provision of residential care for older people.</p> | <p>and discussion of issues facing inspection in 1996, from user, provider and regulator perspective, even if sample and methods are poorly described. A lot of the recommendations have subsequently made their way into policy.</p> |
| <p>Redmayne, S. (1996)</p> <p>Spotlight on Homes for the Elderly: an analysis of</p> | <p>200 reports for older persons residential care homes, from 7 local authorities encompassing</p> | <p>7 local authorities were selected, which were a mixture of northern and southern counties, and county and urban authorities. All reports from</p> | <p>Data were analysed by simple frequency calculations of requirements and recommendations, as they appeared in reports. There</p> | <p>Only used 7 local authorities, but these were purposively chosen to be representative.</p> | <p>Provides guidance for development of standards and methods of standardising the construction and</p> |

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| <p>inspection reports on care homes for the elderly</p> | <p>northern and southern localities and county and urban authorities.</p> | <p>homes inspected over a 2 or 3 month period were examined. 200 reports were analysed, from residential, Dementia and dual registered elderly homes.</p> <p>Issues mentioned in the report were graded depending on whether they were mentioned negatively, positively or not at all. Requirements and recommendations were also coded and given a value from 1 to 3 depending on the perceived severity (arbitrary, subjective ratings). The overall picture of the home was taken into account as well as the fact that some requirements may have been carried over from previous reports. Timescales for requirements were also coded.</p> | <p>were no statistical tests.</p> <p>The aim was to find out how useful reports can be as intelligible information to potential customers of residential care. The main questions were: What standards are the homes achieving and which standards cause problems? Are there inconsistencies over whether improvements are enforced as requirements or only made as recommendations? Does analysis of the reports reveal anything about the nature of the inspection process?</p> | <p>Research provides a ‘snap shot’, which can act as guidance to the issues, both negative and positive, facing inspection reporting.</p> | <p>dissemination of inspection reports.</p> <p>Builds on method of reporting and provides recommendations to standardise reporting across local authorities.</p> <p>Indicates areas that should be incorporated into inspection reports, e.g. continual picture in one report rather than several disassociated reports.</p> |
| <p>Counsel and Care (1995)</p> | <p>Residential care homes for older</p> | <p>The aim of this study was to gain a view of inspection</p> | <p>The report only used 100 out of 103 responses for</p> | <p>325 randomly selected residents</p> | <p>Can provide advice to inspectors and</p> |

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| <p>Under Inspection</p> | <p>people in the Greater London area.</p> | <p>as seen by the homes, consulting residents, relatives and home managers. The study took a very similar form to the Day et al report, also included in this review.</p> <p>Questionnaire – managers The revised questionnaire was sent to 325 homes in the Greater London area, chosen by random selection from the counsel and care database.</p> <p>They received 103 responses, but for ease of analysis only used the 1st 100. The questionnaire was completed by: the manager in 48 % of homes; Owner in 17 %; Owner and manager in 28 %; 7 % were filled in by senior care staff or assistant directors of the home</p> <p>Interviews – residents 20 interviews in 10 homes, all of which the researchers</p> | <p>‘ease of analysis’.</p> <p>The randomness of the selection is also questionable because presumably those who replied felt strongly about the inspection issue.</p> <p>The interviews of residents were not randomly selected, and were taken in homes which the manager had already agreed to participate. This suggests the home would be better at disseminating information about inspection and therefore the residents and relatives might know more about it than usual.</p> | <p>selected from the greater London database were sent questionnaires; 103 replies.</p> <p>Interviews <u>Residents</u> –20 residents were interviewed. Not representative.</p> <p><u>Relatives</u> –In total 13 relatives were interviewed; not representative.</p> | <p>legislators about stakeholders views on inspection, both its impact and effectiveness. This can lead to suggestions for changes in the process to make it both more effective and more relevant to those who the process works to help.</p> <p>Help inspectors to improve their work practices, provide better inspections and be more reflexive.</p> |
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| | | <p>had already received a reply from the questionnaire they sent</p> <p>Interviews relatives</p> <p>They also used homes that had already participated to make contact with relatives. They sent 92 letters to 23 homes asking relatives to participate. In the 10 homes they visited to do the resident interviews, they left 5 letters with the manager to be passed on to relatives, who then had to make contact.</p> <p>In addition the authors contacted the Relatives Association for names of people who might be willing to participate. In total 13 relatives agreed to participate from the relatives association.</p> | | | |
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FINDINGS: THEMES

The 6 studies provided 13 themes of data.

Theme 1: Consistency of inspection

Gibbs and Sinclair (1992a and 1992b) in two papers, based on the same study, included in this synthesis looked at the consistency of judgements between inspectors and quantified their findings using the *kappa* statistical test.

Although this study looked at the consistency of inspectors judgements, and in doing so the efficacy of inspection at producing consistent and accurate judgements of the quality of older persons' residential care, because data were only collected at two points in time the study did not meet the criteria for the effectiveness section of the SR. The authors examined the reliability of inspectors judgements by cross-tabulating judgements made on the first visit with those made on the second visit, to see whether the judgements of the two inspectors corresponded.

Level 1 and 2 judgements – no reliable measure of quality

Initially the authors examined what they termed, level 1 and 2 judgements. To form these judgements inspectors were asked to make a judgements based on criteria for 49 individual variables within the home. These 49 variables were taken from a checklist developed in conjunction with the Homes are For Living In (HALFI) checklist developed by the SSI and another developed by Jonathan Bradshaw, the authors' colleague at the University of York.

Examination of consistency of inspection showed that only 2 of the 49 level 1 HAFLI items reached *kappa* values which placed them in the 'moderate' levels of agreement between two different inspectors making judgements using the same checklist (a *kappa* value between 0.41 - 0.60), 13 were 'fair' (a *kappa* value between 0.61 - 0.80); and the remaining 34 were either 'poor' (0.01 – 0.20) or at best 'slight' (0.21 – 0.40). This demonstrates the lack of consistency between the judgements of inspectors, even when they were supposed to be checking against a standardized checklist.

Sinclair and Gibbs (1992a) claim that inspectors coming 'cold' to a home that they are not familiar with cannot make consistent judgements on the quality of care. If there is to be consistency between judgements of services then there needs to be a formal mechanism, and criteria for making specific judgements. There has to be some kind of formalised guidelines that present explicit criteria the service must fulfil if it is going to receive a certain score for a certain quality item, as well as familiarity with the service.

Although the results were very poor across all types of homes the findings could not provide **any** form of reliable measure of quality for local authority homes. Gibbs and Sinclair speculated that this was either because inspectors were less accustomed to inspecting these homes, or because of the greater complexity and size of local authority homes. They argued that what was needed were adequately trained staff deployed in appropriate numbers, calculated based on an assessment of the challenges they face.

The authors concluded that the unreliability of the measure on local authority homes is more likely to be as a result of an absence of findings than as a result of misleading ones; therefore variables that do indicate some measure of quality are still interesting. According to their findings quality of care in local authority homes is dependent on the following variables: proportion of trained staff on duty, the number of staff on duty and whether this is adequate to cover the duties required – these conclusions fit with other findings, for example Evans et al (1981) and their findings on poorly trained staff and severely dependent residents.

Inspection of the independent sector provided more reliable results, they were mainly small homes and the findings suggest that those in charge have a major impact on how the homes are run. The impact of staff qualifications and single rooms should be approached with more caution. In the case of charges it is necessary to determine what actually produces quality (e.g. is it because a home charging more can afford to employ better qualified staff?). What is most needed is good managers of homes supported by well trained staff. This requires increased professionalisation, which in turn raises costs.

Level 3 'global' judgements

After finding deficiencies using the level 1 and level 2 judgements the authors then examined the consistency of an overall judgement, by considering the holistic workings of the services, 'taking into account all the items... rated in the previous sections and any other important considerations not covered' (Gibbs and Sinclair 1992a: 540). This produced, what they coined, a 'global judgement'. To do this they were given a scale with six values ranging from extremely poor (1) to extremely good (6). This measure was related to more detailed ratings the inspector had to make about the home at levels 1 and 2, for example the level of autonomy of residents, suggesting the inspectors were consistent in the values on which they based their overall ratings, even if they did not agree on the quality of more specific level 1 and 2 variables.

When applying this scale inspectors appeared hesitant to be overly critical of homes, demonstrated by the fact that none of the inspectors in the study were prepared to use the extremely poor (1) or very poor (2) global judgement. However, they used poor on 15 occasions (5 on the first visit, 10 on second visit) and extremely good on 5 occasions (3 on first visit, 2 on second visit), from a total of 96 judgements (from 48 homes, which were judged twice; initially, and then 4-6 weeks later). Of the 15 homes rated poor only 3 were rated so on both occasions. None of the homes rated 'extremely good' during the first visit received an equally high appraisal from the second visit.

Not surprisingly, using the *kappa* assessment rating the agreement between inspectors on all homes was only 'slight' ($kappa = 0.17$) (in terms of the Landis and Koch (1977) benchmarks: <0.00 = poor; $0.01 - 0.20$ = slight; $0.21 - 0.40$ = fair; $0.41 - 0.60$ = moderate; $0.61 - 0.80$ = substantial; $0.81 - 1.00$ = near perfect). There was, however, a stark difference between the types of home: the *kappa* values for local authority homes were 0.18, for private homes 0.33, and for voluntary homes 0.35. There was **no** agreement between inspectors over local authority homes; for private and voluntary homes the agreement was greater than that of chance but lower than the authors would have hoped.

Sinclair and Gibbs' (1992a and 1992b) findings show that there is a problem with the reliability of global inspection judgements when made using a checklist developed from HAFLI. This problem appears to be two-fold. First, if there is no consistency between the

inspectors on the more specific, lower level judgements it is unlikely there will be very good agreement at the 'global level'. Secondly, there is obviously not a sufficient mechanism to translate the lower level, itemised scores from the level 1 and 2 judgements into a corresponding 'global judgement'. However, translating the specific judgements into global judgements is not straightforward, while doing so might be expedient in terms of the consistency, it can pose difficulties in terms of equating the values of each individual item and determining whether some factors have to be 'weighted' as being more important to an overall quality judgement than other items. It is also important to note that the consistency between the standardised level 1 and 2 judgements was still very poor, which demonstrates that formal standardisation of judgements does not always lead to consistency either. The possibility of 'any other important considerations not covered' (Gibbs and Sinclair 1992a: 550), provides further scope for inconsistency.

However, more positively, allowing inspectors the freedom to include any other considerations, maybe through less rigid, prescriptive means, into their overall rating of the homes gives scope for the use of professional judgement of the inspectors. This important caveat means that inspectors can use tacit knowledge, which may, for example, give the inspector the impression that even though a service achieves good scores on certain standardised criteria, their overall professional opinion of the home is less favourable, or *visa versa*.

Second stage analysis: Could judgements be predicted?

The lack of consistency within Gibbs and Sinclair's (1992a) first analysis of the data led to a second stage of analysis to further test the pessimistic conclusions. The authors wanted to analyse whether they could predict the judgements of the second inspection based on the judgements made in the first. They believed their ability to do this would be enhanced if they:

- a. Developed a score for quality based on the most reliable of the first round items
- b. Took into account the type of home, on the grounds that it is easier to make a judgement over some than it is of others

The authors selected items from the first stage of the research, based on the level of agreement between ratings over the two inspections, assuming that a higher *kappa* value indicated 'better' items. To eliminate the possibility that these items were only reliable by chance they split the second sample in two (based on odd and even reference numbers they were assigned at the start of the project), creating new scores for homes with even reference numbers and testing the reliability on homes with odd reference numbers. This had the disadvantage of producing scores based on only a small number of cases, but the reliability was not biased.

Examination of the second stage research shows that even when using the 'best' items for consistency, some still show 'slight' or 'poor' *kappa* values. Despite these difficulties Sinclair and Gibbs created a 'care' score based on the 12 'best' HALFI instruments selected on the basis of the even number homes. They then calculated this score for the first visit to the odd numbered homes and then the second. The correlation between these two scores was 0.60 (level of significance not reported), and the *kappa* values of 0.25 ('fair').

The authors were then interested in how the HALFI scores for the first visit correlated with the inspectors overall 'global' evaluations of the first and second visits. They correlated 0.66 with the first evaluation and 0.46 with the 2nd ($r = 0.60$). Thus it was possible to derive a checklist score that correlates with both the first and second visit 'global' evaluations, but reliability is poor. The authors cannot be sure that the correlations they report represent causal connections rather than other kinds of associations. They also cannot tell whether residents in homes that score highly on their quality measure are indeed happy.

Can quality be reliably measured?

In testing the correlates of quality it is necessary to determine whether quality can be reliably and validly measured. Gibbs and Sinclair (1992b) conclude that professional judgements tend to focus on process rather than outcomes. If inspection is concerned with questions regarding registration or with providing guidelines to care managers on what is a good home, then reliability is crucial. However, if inspection is more concerned with improving performance then reliability is, arguably, less crucial. Thus it is important to see

how professional judgement relates to that of the residents and relatives, and to indicators, such as staff turnover, occupancy rates, residents mental / physical health. It would also be useful to see if the findings can be supported by new research, for example, how do better qualified staff members improve quality of homes (e.g. what does training provide that makes staff better at their jobs?).

Similarly to the study by Gibbs and Sinclair (1992a and 1992b), Day et al (1996) found great variations between the consistency of local authority inspection, in terms of: standards, budgets (irrespective of the number of homes in the area), interpretation of standards by individual inspectors. However according to their interviews, providers and inspectors agreed that overall standards have risen in homes in the ten year period they examined (1985 to 1995).

A third study in the review Counsel and Care (1995) found inconsistency was a problem and took many forms. In interviews with care home managers they found (each question is stand alone): 20 % had experienced inconsistencies between the same inspector on different visits; 27 % had experienced inconsistencies between different inspectors from the same inspection unit; 28 % between the fire officer and an inspector and 19 % between the inspector and environmental health officer (Counsel and Care 1995). There were also comments from managers who had worked in different homes across authorities and noticed considerable inconsistencies between local authority inspection teams (Counsel and Care 1995). The Counsel and Care survey was of 100 people and while it gives an interesting indication and insight, it is not representative of the national care home population.

Although none of the studies in this review categorically determine how to make inspection more consistent they do show the system in the early 1990s was deficient. Gibbs and Sinclair could not provide a tool that greatly improves the consistency of inspection their work undoubtedly added to the 'cumulative knowledge base' and subsequent legislation has developed ways to improve consistency. This review shows that there is still no robust research to show that the new national method of inspection actually works.

Theme 2: Inconsistency of reports

Redmayne (1996) found inconsistency in the written reports composed by local authority

inspectors. This study was conducted in 1994 at a time when there was no national regulator or standardised methods of inspection and all inspections were carried out by local inspectors. The authors found surprising inconsistencies and gaps in the information presented in the reports. They found that reports varied greatly in style, content and length between the local authorities (from 1-2 to 10-12 pages). Two authorities only addressed physical, structural standards in the reports and assume that resident well-being stems directly from these factors. Some reports contained 'bold statements' that gave the reader very little information on the home; comments such as: 'Those aspects relating to staff which were inspected were found to be satisfactory'. There were also differences in the tone of reports – some positive and some negative. Only one local authority included an action plan in its reports, which it claims "details the agenda for development of the facilities and practices of the home". An indication of a timetable for changes is only sometimes included.

The only similarity between reports across authorities found in the Redmayne (1996) study was that announced reports were longer than unannounced, because they covered the whole service rather than a certain trouble area. Within local authorities content is consistent, demonstrating that each inspection unit, rather than individual inspectors appear to have their own agenda. This finding suggests inconsistency across offices rather than across individuals. A finding that indicates if there was a more consistent inspection procedure and set of regulations, then practices and judgements could be consistent across the country. However, this finding contradicts the findings from Gibbs' and Sinclair's study, which shows that even using a standardised checklist for inspection it is still unlikely that judgements will be completely consistent, especially for local authority run homes. Although some level of consistency can be achieved by using the right indicators (Gibbs and Sinclair 1992a).

In a demonstration of further inconsistency across authorities Redmayne (1996) showed that the threshold of what might be considered a requirement varied; requirements made by one inspectorate could be more serious than requirements made by others. For example, a report from one inspectorate could contain only two requirements, but they could be on major issues, whereas another report in another inspectorate may contain ten or more requirements, but they were only on minor issues (Redmayne 1994).

To demonstrate this Redmayne's report (1996) graded the **requirement** on a level of seriousness from 1 (lowest), 2 or 3 (highest). Of the 200 reports examined in the study: 27.9 % of requirements rated level 1; 52.3 % rated level 2; and 18.6 % rated level 3 (n = 678). Reports with one requirement were split roughly in half between requirements that were rated 1 and 2. There were no very serious requirements in reports with only one requirement in total. The fewer the requirements, the more likely they were to be rated 1 or 2, suggesting that quantity and severity of negative comments goes hand in hand: the reports that contain the most requirements tend to also be the reports for services with the major problems.

Almost half of the minor **requirements** concern the administration and running of the home (47.1 %), reflecting slight changes being made to policies and record keeping in the home. Almost as many were based on structural issues (43.9 %), such as. The rest attract very few minor requirements: staffing (4.8%), quality of life issues (3.2 %) and facilities for residents (1.1%). Of the level 2 requirements, almost half were again structural matters (48.2 %) and over a quarter (28.6%) concern administration of the home. The other categories were: staffing (10.2%), facilities and services for residents: (6.9%) and quality of life (6.1%). The most serious requirements were dominated by structural issues (58.7%), staffing matter concerned 21.4%, quality of life issues attracted 10.3%, while administration concerned 5.6% and facilities and services 4.0% (Redmayne 1994).

The top ten **requirements** (including an amalgamation of requirements around the same issue) stipulated within inspection reports, were (in descending order, n = 678):

1. Fire safety,
2. Health and safety,
3. Miscellaneous records,
4. Administration of medication,
5. staff fire and training skills,
6. staff training / induction,
7. care plans,
8. kitchen,
9. internal decoration,
10. number of staff.

The top ten **recommendations** were (in descending order, n = 355):

1. Care plans,
2. Water temperature,
3. Lift,
4. Lockable bedrooms / cupboards,
5. Health and safety,
6. Staff induction and training,
7. Miscellaneous records required or need updating,
8. Internal decoration,
9. Activities for residents,
10. Bathroom.

The main criteria for requirements and recommendations followed a very similar pattern to negative statements in the reports (Redmayne 1996), which were obviously made to support the prescriptions. It is not surprising that fire safety and health and safety are the two most frequently cited requirements, as at the time of the Redmayne study they were supported by much stronger legislative backing than other areas (Redmayne 1996).

The top recommendation concerning care plans also features prominently on the requirements list, at number seven; suggesting that requirements or recommendations may depend on whether the inspector is making good practice suggestions or more serious, legally enforceable suggestions. An example of this could be when an inspector would like to see more detail in the care plan, as a matter of good practice, rather than as a result of legally enforceable regulations. Redmayne (1996) identifies instances where it is difficult to see why certain recommendations are not given as requirements. The author gives a particular example of case records of individual residents. According to schedule 2(4) of the Regulations the home is required to keep a record for each resident that includes: details of any special needs, any medical treatment required, and other information important to their welfare and health. However, some inspectorates were only making issues concerning care plans recommendations, when in fact they are covered by statutory guidelines and therefore should be issued as requirements (Redmayne 1996). This reinforces both an ambiguity in standards and inconsistency in how these standards are implemented.

The second (water temperature) and third (lift) items on the list of recommendations chart highly partly because one authority placed two standard recommendations on all of their reports, which severely biased the outcomes. Instances such as this further demonstrates the inconsistency of local inspection, and shows the impact that one local policy or guideline can have. It may have been that other homes in the study had deficiencies with their lift, or did not have one installed, but because of the priorities of the local inspection agency this problem did not induce a requirement as it did in one particular inspectorate office. Almost half of the requirements concern physical and structural matters, but the study highlights the fact that this is because structural issues are easier to inspect than quality of life issues and methods to assess quality of life outcomes had not been developed in 1994 (Redmayne 1996).

Focus of inspection on structure and process

The evidence from the study shows that in 1994 inspection was still focused on structural and process issues, with only number 7 on the requirements list, care plans, having any relation to assessing outcomes for service users – and that is only if the information in the plans is compared to outcomes as assessed through consultation with the service user or observation of care. Redmayne speculates that the reports tended to focus on structural and process issues for two main reasons. First, structural issues, such as fire regulations, size of rooms, were specified in legislation and there were clear guidelines on how these regulations should be met. Second, according to Redmayne it appeared that inspection would focus on physical and structural standards in the belief that a good quality of life for residents would automatically flow from these being met (Redmayne 1996). This finding ties in with the findings of Day et al (1995), who found that reports from different inspectorates were very different and prioritised different aspects of care. The findings of Sinclair and Gibbs (1992a and 1992b), Day et al (1995), and Redmayne et al (1996) suggest there are very different inspection practices occur across the country if inspection is left to local authorities.

Redmayne, in agreement with Gibbs and Sinclair (1992a and 1992b), is critical of this focus on structure and process and advocates a move towards focus on outcomes in the inspection process. Subsequent legislation and standards since 1996 have shifted regulation in this direction and wide consultation with service users and professionals (see

Department of Health 2005; Department of Health 2006) has shown that this improves the quality of care in residential care homes and improves the lives of those who use the service.

Theme 3: Reports try to highlight positives

Sharon Redmayne (1996) found there were 1735 positive comments in the 200 reports she examined, compared with 744 negative comments. The vast majority of these positive comments (49.6 %) were on quality of life issues. The rest were structural and building issues (26.2 %), level and quality of facilities (5.2 %), staffing (13.3 %) and administration of home (5.7 %). In comparison there were 744 negative comments, most on structural issues (38.2 %). The rest were on administration of the home (27.2 %), quality of life (15.5 %), staffing (10.6 %) and facilities (8.6 %). These results firmly reflect the focus of inspection in 1994, on process issues rather than outcomes for residents. This data shows that although quality of life issues were not prevalent in legislation and therefore not stipulated in many of the requirements for improvement, they were the focus of many positive comments on the home, which shows that where good practice was being observed it was being done so based on the quality of the life the residents were able to lead. This demonstrates that although progress had not been made in terms of bringing quality of life measures into standards and legislation, that gap was being filled by the professional judgement of inspectors and their desire to ensure quality of life was being reflected in regulation.

Redmayne also found there was at least one positive comment in the report for each of the 200 services; and almost three quarters of the reports had six or more positive remarks. Exactly one quarter had no negative comments. This could be part of a strategy to encourage rather than discourage providers, by giving constructive criticism, but also highlighting what the service is doing well. The study also found that negative comments seem to be concentrated around a small number of homes, which are obviously performing poorly across the board: 10% of the reports contained 42.1% of the negative comments. These suggest that most of the homes are deemed to be providing a reasonable or good level of care; it is the minority who attract the bulk of negative comments.

Theme 4: Conflict of purpose for inspection reports

Day et al (1996) found there are potentially multiple users of an inspection report (home owners and managers, customer, social service purchasers, relatives of current users, inspection unit). This leads to a conflict in terms of what information the report should contain and whether reports should cater for all potential users. The Day et al (1996) study did not provide a solution to this question, but posited the problem as something policy makers and practitioners should consider when developing their reports.

Access to reports and advice to public

There are conflicting feelings about how public availability of reports should be administered. According to the Day et al study (1996) 79 % of respondents believed that reports should be made public, although only following current guidelines. But a vast majority of managers still believe that the reports should be confined to inspection units (95 %), Social services (86 %), and the home (88 %). In contrast, when asked about reports being available in public places less managers were favourable. Only 56 % thought they should be available in public libraries, and 42 % in General Practitioner (GP) surgeries. The data suggests that a high proportion of managers are cautious about advocating free availability of inspection reports, most likely because they realise that negative reports could have a far more damaging impact if they are available more widely. This form self-preservation obviously negates the potential for positive impact (on numbers applying to stay at the home, and reputation) if a home receives a good report, suggesting managers are more concerned with self-preservation than potential kudos.

Theme 5: The ideal report

From the data she collected Redmayne (1994) attempted to develop criteria for the 'ideal' inspection report. She concluded that the onus should be on the inspector to continually update the picture of the home, rather than force potential residents to piece info together themselves. The research showed that although there was a large amount of announced (untargeted overview of entire home) and unannounced reports (targeted to specific problem areas) in 1994 there was no collation of that information for prospective service users. She also found that unannounced reports were regarded as of greater importance by user groups, for the same reasons that user groups felt unannounced inspection were of

greater use: because they catch services in situ, off guard and therefore represent a truer picture of the day-to-day working of the service.

Redmayne's (1994) consultation concluded that reports should include: a general description of the home, the rooms and facilities should be provided; a description of daily life and whether their needs are being met under HALFI themes may also be beneficial. There should be information on staff qualifications and training and an indication of when visitors are welcome (including both family and friends and also hairdressers, religious groups, volunteer groups etc). Redmayne (1994) also concluded that there should be staff turnover figures, with reasons if turnover is high; details of incidents and accidents in the home, including a description of events; and details of complaints and how they were resolved. Conclusions such as these represent a theoretical shift in social care towards a position of empowerment for the service user, as opposed to central distribution of service by government (central or local). By giving them access to as much information as possible, the inspectorate is providing the optimum information for them to make an informed choice about the service(s) they use.

However, as the Counsel and Care (1995) study shows, of the twenty residents interviewed, none used information from inspection units when choosing the home. So even if a report was produced similar in content and style to the ideal described by Redmayne (1996) then there is no guarantee that it will be widely consulted or used. Reports today include many of the criteria recommended by Redmayne (1996), but as this review demonstrates there is no research to provide evidence for effectiveness or usefulness of these reports. There is also no evidence showing whether a better organised and more user-friendly report is used more widely and if this is the case whether it is because it is more appropriate and accessible for service users.

Theme 6: Shift of focus: process to outcomes

Day et al (1995), in their one year study that involved interviewing local authority inspection staff, home providers, and users in England and which also made use of existing data (from the SSI) to examine the performance of inspectorates against government targets, found that the focus of inspection was moving from a focus on inputs to, quality of care as measured by outcomes. This study follows on from the Redmayne study (1994)

published a year earlier and shows the cumulative development of both knowledge of regulation. The studies demonstrate that regulation policy and standards in the 1990s shifted in response to consultation and evidence (both informal / anecdotal and research). However, they also found that there was still a need to develop ‘alarm bells’ to identify things that ought not to be happening, pre-empting problems rather than waiting for unsuitable outcomes to materialize (Day et al 1995). This finding reflects the subsequent shift in inspection policy over the ten years since 1996 and provides evidence that formed part of the knowledge base which brought about a change in ethos in older persons inspection, towards a more outcomes focused approach.

The Day et al (1996) study highlights possible problems with an outcomes-focused approach. They find that looking at outcomes should not be a substitute for other methods because ‘homes tend to shape the expectations of their residents’ (Day, et al. 1996: v) and there is the possibility of institutional conditioning, whereby residents, especially those who have been in the institution for a long period of time, lower their expectations because they have accepted their marginalized position and lack of empowerment to do anything.

Theme 7: Support for national care standards

The Day et al (1996) research also found there was considerable support amongst inspectors, providers and relatives for a move towards national standards of care. Subsequent legislation in 2000 (Care Standards Act) put national standards in place, which demonstrates that the research findings were similar to the prevailing thinking of government and that policy on the issue was enacted with some evidence (in the form of research) of support from key stakeholders in the inspection process. The study did not resolve the questions regarding whether national standards would require a national regulation body, or should be administrated and applied regionally (as was the position in 1996). It was hypothesized that the local model would offer greater flexibility, but the national model would provide greater uniformity and consistency. These views were only speculation and there was no evidence from the study to be sure either way.

In contrast to Day et al’s (1996) study, Counsel and Care (1995) found that ‘two-thirds’ of the inspectors (no percentage reported) thought that inspection should remain under local authority control. Although these conflicting results show an inconsistency in the evidence

base, because of the narrow focus of the studies (Counsel and Care only researched the Greater London Area and Day et al only eleven local authorities – although these were purposively selected to be as representative as possible) this is not too surprising. There are a number of reasons why Counsel and Care may have found opposition to a national body. First, there is a tendency for individuals to want to ‘maintain the status quo’, change is uncertain by nature and therefore people have a tendency to avoid it where possible. Second, it is likely that inspectors would have been worried about their jobs, if a national inspectorate was set up local authority inspectors would naturally be sceptical as to how would fit in and be accommodated by the changes.

Theme 8: Public availability of inspection reports

The Day et al (1996) study concluded that public availability of reports on individual homes could be an important new regulatory sanction. They would provide a mechanism that forced providers to not only be accountable to the inspectorate, but also to the service users. If reports were made public then the user could make an informed choice about whether or not they wanted to live in the home, based on the assessment of the inspection report. However, respondents were adamant that they needed to be more uniform.

As with the discussion on national standards, the public availability of reports has now been implemented into public policy. The advent of publicly available reports on a national scale tied in with the creation of national standards, which meant that reports also became uniform in presentation. Day et al (1996) found no evidence on how many people use reports when they were available.

Theme 9: Stakeholder belief in self assessment

Day et al (1996) also showed that at the time of their study key stakeholders in the inspection process believe that self-assessment could provide a useful addition to the existing regulation system. The research shows support amongst stakeholders for an additional internal regulatory strategy to work in conjunction with the arms length regulation. They also concluded that local authorities as purchasers could provide an inspection function, linking their purchasing to the outcomes of their own inspection activity. This once again demonstrates the prevailing feeling of the time (in 1994), and

subsequent adoption of self-assessment by the current national inspectorate (CSCI), shows that action has been taken in response to stakeholder consensus (as demonstrated by the use of consultation papers by the government to ask key stakeholders what they wanted from inspection, see Department of Health 1998; 2005; 2006).

Theme 10: Regulation is very difficult to cost

Day et al (1996) determined that regulation as it existed at the time of their report was impossible to cost, especially in relation to any cost-effectiveness calculation, because it was too inconsistent across the country. To do this, they concluded, requires the generalisation of best practice, which did not exist at the time. Although there is now a generalization of best practice, in the form of standardised training and standards, there is still no research on the cost-effectiveness of inspection

However, Day et al (1996) did conclude that cost-effectiveness is a useful calculation because standards need to be costed and weighed against other improvements in care that might be forgone as a result of certain standards (such as minimum room size). The authors concluded that the cost of regulation needs to be considered in the light of benefits to residents, regulations should be seen to have a positive benefit in relation to the cost to adhere and implement them. They concluded that calculations which do this were impossible at the time of their study (1996) because there are 107 different regulatory regimes in the UK, each of which have varying responsibilities and which, as Sinclair and Gibbs (1992 a and 1992b) and Redmayne (1996) have shown, implement regulations in different, inconsistent ways.

Theme 11: Impact of regulation on Managers

Positive view of inspection

The survey suggests that managers see inspection as positive and believe that it drives up the standard of care, 50 % think inspections can ‘very much’ positively affect standards of service; 36 % think inspections can affect standards ‘a little’; 13 % said ‘not at all’; and 1 % said inspection had a ‘negative’ impact. In a similar vein when asked whether inspection encourages them to do a good job 74 % thought it did, 20 % thought inspection had no

significant impact and 6 % said it hinders the work in the home. In terms of their view of the inspectors, of the 100 managers interviewed 90 % said their inspector was approachable; 55 % said they were challenging; 84 % said well-informed; 94 % said thorough; 77 % consistent; 80 % supportive. Inspection was viewed by the Counsel and Care sample as a positive intervention that can help the care homes improve their service.

Managers also felt that regulation had improved over recent years (up to 1996), 56% of respondents thought the inspection process was now more helpful as a result of changes in recent years, 23% felt it had stayed the same, 14% thought it was now less helpful and 7% made no comment. This demonstrates that the evolution in regulation was, at least according to the Counsel and Care (1995) sample, progressing in a positive direction.

Process and structural issues should complement the focus on outcomes

Gibbs and Sinclair (1992b) found when discussing their findings with inspectors that they thought measures of quality outlined in their paper that focused on outcomes need to be complemented with more traditional measures, such as fire regulations. Managers were wary that a shift to focus outcomes, away from measurement of processes, might shift standards away from some important safety issues, a move that they thought unacceptable

Inspection should be a mechanism for advice and support

When asked which aspect of the inspection process is most useful 58 % of managers said that discussing issues with the inspector was most important; 17 % thought getting advice; 10 % thought the follow-up report; 7 % the scrutiny of systems; 6 % a tour of the home; 2 % the inspection form. In relation to this, when asked to answer 'yes' or 'no', 99% of inspectors said they would like to have more advice from inspectors; 83 % said they would like more training; 94 % said more support; and 100 % more information.

Counsel and Care (1995) present a clear picture of care home managers looking to inspectors for positive help. When asked what issues they would like advice on (yes or no question): 94 % said yes to advice on national policy changes, local policy changes (99 %), how to meet standards (96 %), good care practices (84 %) and legal issues (81 %) all featured very highly. They would clearly like to see the inspection role as one of support

and advice, as opposed to simply regulating. The vast majority (94 %) also feel this advisory role should extend to helping residents make choices about which care service to choose. However, how this should be operationalised was not a focus of the Counsel and Care report. The managers asked for advice from inspectors, but whether they would have accepted advice in the form of supporting (general) information and guidance produced by the regulator, rather than (specific) advice from individual inspectors is not made clear in the research.

Manager's use of reports

When asked about their use of the report 59 % of managers claim to refer to it regularly, 85 % discussed it with owners or management committee, 91 % discussed it with care staff, 92 % with senior staff. However, only 53 % of managers discuss the report with residents and 47 % with relatives. This suggests managers see reports as providing evidence of the need for change and are accepting of the role of external regulators as a 'check and balance' against complacency in the service they offer. They also use the report as an incentive to enact change and to provide leverage to staff by discussing the issues within the report and using it to improve working practices where necessary. There were still a large number of managers who do not consult with their residents and / or relatives about the report or discuss how changes can be made in response to the reports findings. Considering that the service is provided for the residents this figure is surprising.

The negative aspects of inspection

70 % of managers found inspection time consuming and 75 % found it over bureaucratic, but only 26 % found the inspection process negative. A key criticism was that 'rules change constantly'. 40 % of managers surveyed thought that the inspection unit not was independent of the social service unit. It was not thought to be at 'arms length', especially because at the time of this study many services were both run and inspected by the same local authority. This finding from Counsel and Care (1995) is similar to Gibbs and Sinclair (1992a and b), who could not provide a reliable measure of quality for local authority homes, when their tool was found to be reliable to measure quality in privately run services.

Theme 12: Impact of regulation on residents and relatives

Residents' awareness of inspection process

When Counsel and Care (1995) interviewed service managers 53 % said they discuss the inspection report with residents. However, most residents had no idea what an inspection unit was; when asked if they knew who checks standards in homes 11 of the 20 looked blank. However, two knew the name of their inspector (because they had been visited two days before) and the other seven had some notion that an 'authority' comes around to inspect the home. Only four residents claimed not to ever have been aware of inspection, but the others were aware either from staff telling them or noticing activity within the home, only two had had (or could remember having) direct contact with the inspector.

When relatives were questioned only one relative had read an inspection report and most expressed the need of relatives to be vigilant in maintaining standards; one relative said that relatives have a responsibility to their family members in care, they should not just "dump them and leave them". Of the thirteen relatives interviewed eleven had direct involvement in selecting the home. In the two other cases either another family member made the decision or social services had to place the resident in an emergency and this situation gave the resident or family no choice. In terms of information used to choose the home: four relatives received information from Social Services, although for two of these the information was not wholly appropriate (one case info given was for homes which did not meet the needs of the client, in the other the fees were higher than the clients income), four used GPs or a hospital social worker, two used Counsel and Care's Homes Suggestion Service, two used local knowledge and two responded to direct advertising. This suggests, even from such a small sample, that information on homes from inspection is rarely reaching those needing help to choose a home.

Evidence from Counsel and Care (1995) suggests that relatives wish to take an element of responsibility for the service their family member receives and suggests that they would be proactive if something was wrong (either complaining or moving their relative). However, the evidence shows that only one relative had read an inspection report; it is likely that because they know little about inspection, relatives feel more comfortable in taking the responsibility for their family member's care because they feel uncomfortable relying on a service of which they have little knowledge. It also appears that relatives are more

comfortable to take advice from ‘familiar professionals’, those whom they know and / or trust because of their professional position. It appears from the Counsel and Care (1995) data that inspectors and the regulatory service is not held in this level of esteem. This is further supported by the fact that only half of the interviewed residents (ten) would like to view an inspection report; six did not want to and four did not mind either way. None of the twenty knew that the public were able to read the reports.

This need for more resident and relative involvement is supported by the way in which relatives responded to Counsel and Care (1995) questions on how they thought inspections should be carried out. One relative commented that they should have a more active role in inspection, because they are in a unique position to be able to comment on the report and pick up on any inaccuracies.

Residents can be wary of consequences of speaking to inspector

One resident admitted that some other residents were afraid to speak to inspectors because they felt ‘they could get a bad time’ (Counsel and Care 1995). Only one resident would consider making a complaint to an inspector but only after speaking to the manager, thirteen said they would speak to the manager of the home rather than speaking to an inspector. Others were quite adamant about not going to an inspector. Two residents felt that no one could help them if they had a complaint and if that situation arose they would look for another home.

Targeting inspections on poor services

Counsel and Care (1995) also found that residents believed inspectors should visit homes with low standards more often, and a few explicitly claimed unannounced inspection was the best method. The majority of respondents felt that unannounced inspection was the only way to improve the service – ‘How else can they be improved’ (Counsel and Care 1995: 27) said one. Another said ‘preparations can be made with things covered up... so surprise is very good’ (Counsel and Care 1995: 34)

Theme 13: Regulation can improve urinary incontinence

Fleishman, R. Heilburn, G. et al. (1999) in their study '*Improving the quality of institutional care of urinary incontinence among the elderly: a challenge for government regulation*' set out to investigate whether the Regulation, Assessment, Follow-up (RAF) method of surveillance on older persons hospital and residential care homes had an impact on improving urinary incontinence (UI) in Israel. The method was designed by the JDC-Brookdale Institute, it is based on a tracer approach (see Kessner and Kalik 1973) and on the principles of quality assurance as set out by Donadedian (1991). This method was adopted by both the Ministry of Labour and Social Affairs and the Ministry of Health and the new system, which covers both licensing and surveillance, manages a database of 25000 individuals and 350 long term care institutions (e.g. residential care homes, hospitals).

Caveat for including research paper

Although this paper examined both residential care and hospital care the results were reported separately, so it was possible to pick out only the residential care home data for the purpose of this review. The residential care sector in Israel, according to Fleisham et al (1999), had approximately 7 % of residents who required nursing care but are in residential care because of other extraneous circumstances, such as being close to a spouse. This finding fits in with my initial protocol criteria which stated that no less than 85% of the population of care homes used in studies must be under 65 or receiving any other form of care apart from personal care.

Influences on the prevalence of urinary incontinence (UI) in residential homes for older people: multiple regression

The study used multiple regression to explain the rate of deficiencies in the UI care process, using 'average rate of deficiencies in the UI care process' as the dependent variable and the following as independent variables:

1. prevalence of UI,
2. rate of nurses,
3. rate of physicians,
4. rate of nursing aides,

5. size of institution,
6. ownership of institution
7. devices for washing and disinfecting bedpans.

The model explained 31 per cent ($R^2 = 0.31$, $F = 8.887$, Sig. $F = 0.000$, number of homes in the regression = 160) of the variance in care homes, with four independent variables explaining the average percentage of deficiencies:

1. per-bed rate of RNs,
2. per bed rate of physicians
3. ownership
4. Institution size.

The first three variables showed a positive relationship with the dependent variable, the fourth showed a negative relationship (the larger the residential home the lower the percentage of deficiencies).

The multiple regression model showed that homes which were large and publicly owned and had higher per bed rates of nurses, generally showed better awareness of UI, conducted better examinations of UI, had better guidance for coping with UI, and had better provision for getting people to the toilet on time (Fleishman, et al. 1999).

According to Fleishman et al (1999) the multiple regression analysis shows a relationship between three groups of variables:

1. basic institutional variables (size of home, ownership, understanding of regulatory method) and structural variable (e.g. per bed rates of nurses and physicians) which then influence;
2. the process variable (e.g. examination of individuals, guidance on continence, treatment of UI) which in turn then influence;
3. outcome variables, i.e. improvement in UI

The study comes to the conclusion that on average the larger homes, owned publicly with a good understanding of regulation, will have a greater number of nurses and physicians per bed; the home will, by virtue of these structural variables, be more organised and therefore have the best management of UI and provide the highest chance of improvement in UI.

The impact of regulation

In relation to the effect regulation has at improving the treatment of UI the study shows that two main areas that have an impact on the prevalence of UI in residential homes: structure and process and that improvement in these areas should result in outcomes beneficial to the resident. The following sections show how effective regulation is at improving these areas, which then, as the regression above shows, will then help to improve the management and treatment of UI.

Structural issues

In relation to the impact of regulation on structural deficiencies that if improved would improve the treatment of urinary continence only the per bed rate of RNs improved from 59 % of institutions during the first cycle (1987-1988) to 44 % during the fourth cycle (1994-1996). For the remaining structural items involved in UI there were very high proportions of residential homes with deficiencies that did not improve over time.

Process issues

With respect to the process items in the study, the regulatory system showed major improvement over time in residential care. Awareness of patient incontinence improved from deficiencies in 86 % of cases during the first cycle of inspection to only 5% at the fourth cycle. Improvements were also seen in medical examination of incontinence (from deficiencies at 92 % of the homes to only 33 % by the fourth cycle), in assistance to reach the toilet in time (from 25 % of homes with deficiencies to 20 %) and guidance for coping with incontinence from 56 % to 36 %).

Fleishman et al's (1999) analysis shows that once they are picked up by regulation, process issues appear much easier to fix than structural problems. The authors speculate that this is likely to be to do with costs because many process problems can be resolved through organisational changes or changes in staff behaviour, which often cost little money. In relation to outcomes 34 % of elderly in residential homes who were incontinent during the first assessment were continent two years later. The study assumes that this is due to proper treatment being called for by the Service for Aged regulatory system, which then

influences structural (less so) and process changes to decrease deficiencies in urinary incontinence care.

DISCUSSION

This chapter shows there is no existing evidence on the effectiveness of inspection. There is a lack of UK-relevant, good quality evaluations (either controlled or not) for residential care for older people. The study by Gibbs and Sinclair (1992a and 1992b), represented in this review by two papers, did attempt to look at the consistency of inspection, but was deemed of insufficient quality (according to the review protocol) to provide evidence of effectiveness. It was included in analysis of the impact of inspection. Their study does show that there needs to be more consistency in the application of standards and implementation of overall judgements about the quality of a service. A second study included in this review by Redmayne (1996) looked at inspection reports, and she found that as with the inspection procedure these were also inconsistent, both in the style and focus.

There are also very few studies that measure the impact of inspection, and all evidence found during the search was published in the 1990s and is now out of date. There needs to be further investment in research that will examine the impact of inspection as it is today. The included studies, especially the Day et al (1996) and the Counsel and Care (1995), do give evidence as to what the key stakeholders in older persons' residential care (residents, staff, managers) think about the process of regulation and what perceived impacts it has, either on the quality of care or the running of the service. However these studies were conducted in the mid-1990s and regulation has evolved considerably since the publication of the studies included in this review and they are now not relevant today. They do provide some evidence to assess whether inspection and regulation evolved as the evidence based suggested it should. Obviously, it is impossible to claim for certain that changes to legislation and regulation practice occurred as a direct result of the evidence available, but they followed the same direction as the established evidence base, even if it is not possible to categorically say that the studies were used to influence change.

A dearth of studies

One of the biggest difficulties in finding studies which solely focused on residential personal care for older people, as opposed to nursing care, is that in the United States of America, and those countries with systems based on the US model (e.g. Israel, South Korea), the term ‘long-term care’ can signify either nursing or personal care provision, and there is often little distinction made between the two. It also became apparent during assessment of research which reached the ‘full text’ stage that the same is often true of UK based research; research into ‘care services’ or ‘social care’ tend to encompass both nursing and personal care. Therefore searches come up with a large amount of nursing care articles, or articles that examine nursing and personal care as a homogenous service. The protocol of this SR focused solely on residential personal care for older people, with a specific decision to exclude nursing care. The rationale behind this decision was to avoid crossing the boundary into medical research. A decision made for two main reasons: First, regulation of the medical model can involve complex medical procedures, which I hypothesised, because of the volume of medical research, would take over the study and draw me into a field in which I have no knowledge or expertise. Secondly, this SR is also acting as an antecedent to the primary research of my doctoral thesis, which focuses on personal residential care, rather than nursing care.

Articles on the effectiveness or impact of the regulation of nursing care are far more common than those on the regulation of residential personal care (see Appendix 1). This reflects a burgeoning of research in nursing care in comparison to residential care, particularly in the US, where nursing provision is more common than residential provision as it is funded through the Medicare insurance system.

One of the reasons for this appears to be to do with the funding of the two types of care. This SR demonstrates that most of the research into regulation of older persons’ nursing home care appears to come from the US. Board and care facilities are the US equivalent of residential care homes in UK, but they are not funded by health insurance. This means that board and care facilities in the US are funded through private payments by residents and as a result there are no stakeholders with a large enough interest to fund research. They are still regulated (licensed and monitored) by state or local authorities. Much of the US research found during this SR focuses on nursing or skilled nursing facilities (SNF)

because they are eligible to receive insurance payments, which makes them a much more attractive option to fund research into because the state insurers can make savings if research pinpoints improvements.

A second reason could reflect the similarity between the majority of aspects involved in both nursing and non-nursing care provision. Within residential care issues around choice, food, well-being, respect, dignity and the other areas protected by government standards are similar in both nursing and personal care; nursing care simply has an extra, health orientated dimension. Thus it is possible to conduct the same research in nursing services (without focusing on the health issues) as in personal care services; to not do so would eliminate a key population from the sample. However, it was not appropriate to include this sample in my SR, because although it would widen the scope of the study to include articles which looked at aspects important to **both** personal and nursing residential care homes, it would also widen the scope to the extent that I had to include research into the effectiveness and process of inspection and regulation on the medical aspects of nursing care, a field I wanted to avoid.

This SR highlights the lack of 'scientific' studies carried out on residential social care inspection for older people (and I extrapolate this reflects the whole of the social care field). There are a number of reasons for this. The first reflects a widely cited criticism of social work research; that it is reluctant to adopt and embrace evidence-based methodology. A failing which can be attributed to a number of causes: the lack of a quantitative skills base in social work, and the social sciences more generally; concerns about the appropriateness of applying a methodology rooted in the natural sciences to a social setting that is heavily influenced by the social interactions within it, and the ensuing problems with measuring these interactions; lack of funds channelled into financing multi-site, researcher laden projects.

Aside from the practical barriers to effectiveness studies in the social sciences, there are also substantive considerations, the most defining being the problem of subjecting a social care setting to a wide scale intervention over a sustained period of time. To do this can have both practical and ethical implications. On the practical side, the invasiveness of a study which measures effectiveness means that it is a daunting prospect to undertake and will encounter numerous problems with gaining and sustaining participants. There are also

complex ethical considerations regarding the allocation of interventions and the problems associated with negatively or positively affecting a certain population in contrast to the rest. However, these considerations are also apparent in the trial of clinical interventions and in the context of devising research I agree with the old, but wise adage that problems should never be dismissed simply because they are too difficult.

Recommendations for further research

There is a lot of money being spent on regulation (CSCI's annual resources in 2005-2006 were £151 million (CSCI 2007a: 61)) and it can be quite a burden for services, so evidence that inspection actually works to improve outcomes is long overdue. There is a great need for further (well-funded) research into older persons' residential care, at the moment there is no evidence to demonstrate whether inspection and regulation actually works to improve outcomes for any of the key stakeholders (residents, staff, managers). Nor is there any detailed research into whether inspection is a cost-effective process. Netten, Forder and Knight (1999) conducted a study for the Personal Social Services Research Unit (PSSRU) that looked at the costs of regulation in 1999, prior to the inception of either the NCSC or CSCI, but this was not included in the review because it looked at care homes for all adults, not just older people.

Now that regulation is administered nationally, by a central organisation it should be possible to conduct a large-scale study into the effectiveness of inspection and regulation, both in terms of cost effectiveness and effectiveness at improving outcomes for service users. This would be a large, costly study that would require more than one researcher and have to involve assessment of outcomes for the service user, with direct consultation of those service users. As inspection must occur at least once every year (see CSCI 2006d) in the most poorly performing services, with regular follow-up inspections to monitor improvement, it would be difficult to do a wide ranging Randomised Control Trial (RCT), but it would certainly be possible to develop a method to judge effectiveness.

This SR also highlights the perceived lack of relevance and dissemination of reports and consequently the reluctance of potential and current service users to read them. Redmayne (1994) made a number of recommendations for the composition of inspection reports and those produce by CSCI include many of the criteria recommended, but as this review

demonstrates there is no research to provide evidence for effectiveness or usefulness of these reports, or how widely they are used. There could also be further research into whether this better organised and more user friendly report produced by CSCI is used more widely, and if this is the case whether it is because it is more appropriate and accessible for service users.

REFLECTIONS

Definitional problems: Assisted living

When I embarked on this review I did not fully appreciate the complexity of the older persons' social care field in relation to the types of services that are available and the confusion that the differing terminology creates. This issue is particularly highlighted when searching international studies, which often focused on assisted-living facilities. Rather than being a service that provides institutional, residential care, assisted living facilities are for people who can no longer live on their own, but do not require nursing or round the clock personal care, much akin to domiciliary care in the UK. In this semi-institutional setting people live in self-contained flats, but with the provision of personal care services available to them on site. These studies were not included in the review. It also appeared common, especially in the USA and countries that use similar frameworks and policies for care (e.g. Israel), that there was not often a distinction between nursing and residential care and these two terms were used interchangeably, even when the type of care being provided may have been solely personal, with no medical treatment offered. It also appears that registered nurses tend to be in charge of running residential care establishments in the US, and associated countries, if not providing the bulk of the care, even if this care is solely personal, non-medical.

A rigid protocol

When I began my SR, I was heavily influenced by the guidelines of the Cochrane Collaboration and the necessity to develop a protocol with methodological inclusion criteria that adhered to a stringent scientific evidence base (see Appendix 1 for protocol). As it transpired this inclusion criteria was very narrow and did not generate any effectiveness studies on the regulation of older persons' social care. This led to weeks and

months of demoralising database searching. I acknowledge that a negative result, i.e. one that comes up with nothing, is valuable in its own right, but developing an inclusion criteria that is very narrow, based on a set of values that I argue better fit (although not exclusively) the natural sciences, was naïve for a research student. What was more appropriate, and became an added dimension when I re-worked the SR was to widen the methodological inclusion criteria. The two parts of the protocol were divided and this is reflected accordingly in the weight with which the evidence is presented in the final report. I split the question in two to look at *effectiveness*, using a hierarchy of evidence, and *process*, using a quality criteria developed by Kavanagh, Harden et al (2005) in an SR they completed for the Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre). These criteria centred on a suitable description of methods used and whether these were appropriately justified in the context of the research question(s) of the study. This led to a small number of studies meeting the inclusion criteria of the process question, but the narrow focus of the question still meant that quite a few studies were excluded simply because they focused on wider residential care (including nursing and / or those under 65), rather than residential care for older people.

The eventual lack of studies included in the review led me to question the **appropriateness of the question** and whether it was too narrow, even once I had divided the review into process and effectiveness questions. It is imperative to have a question that is not only clearly thought through but also worded extremely carefully. The structure of the question ultimately determines the inclusion criteria and search terms of the protocol because it defines exactly what you want to examine. The question therefore needs to be succinct and well constructed to reflect search aims and form a foundation for the review, because from this you will develop a search strategy. I think the question was worded well and allowed me to answer both the effectiveness and process questions. Although there were very few studies, a negative result is not bad and shows a lack of research in the area. To have widened the focus of the review would have made the project too large to manage single-handed. I would have had to include and examine studies that focused on health and nursing issues, which as well as widening the whole scope of the SR (to proportions impossible to cope with during my PhD) it would have taken me into territory that I have little knowledge or expertise in.

Limitations

Scope of search

Once the question has been defined and search terms finalised there had to be consideration of the scope of search, this was especially important because I did not have the resources to conduct a full SR. Decisions had to be made about;

1. Focus: International or national?
 - a. Publications in native language only?
 - b. Translation – if so, how? Cost?
2. Types of databases
 - a. Only ones that the University of York or my sponsor the CSCI carry?
 - b. Pay for subscription to relevant databases that affiliated institution(s) do not carry?
3. Financial limitations
4. Time-scale (especially with one researcher)

In keeping with an initial adherence to a traditional protocol I opted to look internationally, but decided not to include research that was not written in English because I did not have the resources to pay for translation. This obviously puts a limit on the scope of my SR and I can only say that my findings are true to the extent that they ignore research in other languages, a severe limitation.

I decided that without anything but a very small expenses budget I would only be able to search databases that were either free to access, or the University of York, or my sponsor CSCI had access. Doing this restricted my scope and meant that I could not access some of the search database I would have done had I had more resources. Databases I failed to access included Ageinfo, Social Sciences Citation Index, Bibliography of Asian Studies, Social Work Abstracts.

Inter-rater reliability

The average SR in healthcare costs around £80000 (as estimated by Petticrew and Roberts (2006) using a median calculation of funding from information on the UK Health Technology Assessment Agency website) and involves a minimum of two researchers

(often with additional search specialists) who can discuss inclusion decisions and come to agreed conclusions about whether the particular piece of research should be included as defined by the parameters of the protocol. Inter-rater reliability was a problem because a PhD is essentially a very solitary endeavour and I had no resources to pay a second person to help examine the search output. This meant I had to make inclusion decisions on my own, without the use of inter-rater reliability to boost rigour.

Databases

Once title, search terms and inclusion criteria have been developed and before I embarked on any data collection it was pertinent to explore each of the databases that are going to be used for the search. I only did this for two of the databases I used, CSA illumina and OVID, and this led to problems when I came to searching the others. I found that I often had to tweak my planned strategy to fit with the idiosyncrasies of the particular database, which led to a great deal of frustration and also became very time consuming. For example the advanced search option on Social Care Online involves a complex combination of 'field tags' (e.g. author, title) that you have to copy and paste into a window and combine as required (see <http://www.scie-socialcareonline.org.uk/AdvancedSearch.asp>).

A number of databases also crashed on me during my search of the outputs: for example social Care Online (21/04/06). These problems occurred because for some of the databases I naively attempted to examine the output *in situ*, on screen rather than exporting the output to a relevant reference-managing programme, or even to a text file. Valuable time was lost on these errors and in future I will ensure that I can save and or export my search output before I begin applying my inclusion criteria.

Searching and saving

I also had a problem dealing with duplicate 'hits' in the search output. Once again this was mainly due my naivety of the method and my lack of fastidiousness in exporting outputs appropriately. It was painstaking to eliminate these duplicates manually, especially when I got into the position of doing it *in situ* as I was making inclusion decisions. Therefore, if I were to conduct another SR I would ensure I had a method of eliminating duplicates before

I began making inclusion decision. This would be achieved by saving my search outputs appropriately before I begin the sifting of studies.

The final writing for the review took place quite some time after the search, which meant that it was necessary to be fastidious in organising search outputs, something which I did not do as well as I could have done. Using an appropriate data management programme and ensuring that I saved full searches properly would have greatly improved my organisation.

Analysis

I realised it was important to make detailed notes on output that may have met the inclusion criteria, which I put onto a data extraction form (see Appendix 1). I then used this at the analysis stage, often without the need to refer back to the study, because the detail of the extraction form was comprehensive. This was helpful and certainly made writing up more efficient and straightforward.

Conducting a Systematic Review (SR) for a PhD

I argue that the key to conducting a SR for a PhD and making decisions about how to develop an appropriate protocol is to always to maintain the maxim: is what I'm doing fit for purpose? While it will not be possible to follow every criteria of a traditional SR, in order to retain the essence of the technique and distinguish what you are doing from a simple narrative literature review there are certain facets that I argue must be retained:

1. Refined research question
2. Transparent methodology
3. Stringent and clearly defined inclusion criteria based on your research question
4. Stringent and clearly defined methodological criteria – not necessarily based on a hierarchy of evidence, but ensuring there are clear lines drawn between what is and what is not an acceptable methodological standard (which may be as simple as a clearly defined and justified methodology)
5. A clear procedure for analysis
6. Locate relevant databases to search and relevant organisations and individuals to contact asking if they are aware of any existing research o your topic area

All of these issues need to be clearly discussed in a detailed research protocol, defined prior to any of the review taking place. However, there appear to be one or two key facets of the more comprehensive SR that, as I have discussed, are particularly difficult for a PhD researcher to build into their protocol.

A SR can be a very useful research tool, either as a literature review for your thesis (at a time when systematic searching is being increasingly advocated in more traditional literature reviews), or as a thesis in its own right. However, it is important, as with the methods that might be employed when developing inclusion and quality criteria within a protocol, to ensure that this is fit for purpose. By which I mean developed within the confines of research circumstances. This is even more important for degree level researchers who have to deal with limitations that a fully funded research project will not.

However, while these issues have to be taken into account it is necessary to avoid the stretching of the concept on an SR to the extent where the essential principles are lost. A SR should exhibit certain characteristics and where corners have to be cut these must be explained and justified and can only be done so in the confines of the method providing the essence of the SR is retained.

Informing Phase Two of the Thesis

The systematic review represents a self-contained piece of research and was written to stand alone in its own right. It was written in response to a direct request from the CSCI and as such was led by their requirements. In this sense it is phase 1 of the research and it informs the more extensive phase 2. In light of the Systematic Review findings the third part of this study investigates the impact inspection has on service provision, focusing on: the reaction to inspection findings of stakeholders, the extent to which it leads to improvements over the case study period and the barriers to implementing service improvement.

CSCI figures suggest the changes to inspection implemented since 2004 have produced a more effective inspection. Services are now meeting 23 % more standards than in 2003, with the average percentage of standards now being met by older peoples' care homes at

82 % (CSCI 2009). The systematic review in this thesis suggests there has been no research to explore the process of inspection and understand how and why inspection is working and if the official figures tell the whole story. The aim of phase 2 has therefore been to understand this process and the rationale that underpins it. This has been achieved through the observation of four separate inspection visits and subsequent discussions with the inspectors and other relevant stakeholders. The emphasis has been on exploring themes across the four inspections and understanding the consequences of inspection.

CHAPTER 3: METHODOLOGY

This chapter sets out how I carried out my research. Rather than just being a simple account of what I did it chronicles my thinking from the development of the study and considerations of appropriate methodologies, to how this thinking draws on literature about research methods. I also include a reflexive strand throughout this chapter, tracing the evolution of my thinking and reflecting on the inevitable design changes that occurred throughout the research process.

PLANNING

Aims of research

At the inception of this study there were two aims, first to determine the consequences and impacts inspection had on stakeholders involved in residential care for older people. The second incorporated an evaluative element to the design, as it was also part of the CSCI's wish that I should explore the extent to which inspection would lead to improvements in care.

Elements of research and evaluation

These aims posed an initial methodological question about the differences between research and evaluation. I had the ambitious aim at the start of this study to address both practical and theoretical problems in relation to the inspection of residential care homes and produce findings that would culminate in both description but also policy and practice recommendations. This posed an interesting methodological conundrum because some literature seems to suggest that there is a distinction between the two (see Guba and Lincoln 1989), but others, such as Campbell and later Shaw suggest they are inclusive of one another. Shaw (1999) suggests that in asking whether evaluation and research are different we are making judgements about theoretical, empirical and normative positions.

1. *Can* research and evaluation be similar / different?
2. *Is* research different from evaluation?
3. *Should* research and evaluation be different? (Shaw 1999: 8)

Others who have written on these issues, such as Guba and Lincoln and Ernest House argue that a dichotomy is appropriate because the two types of research have different purposes (understanding versus technical assessment) and different audiences (heterogeneous evaluation audience versus homogenous research audience) (Guba and Lincoln 1989). Certainly, public sector organisations and ethics committees make distinctions between the two (see for example Eckstein 2003).

The approach I take in this thesis takes much from the work of Weiss and her conceptualisation of evaluation as encompassing enlightenment, ‘whereby there is a diffuse and indirect infiltration of research ideas into... understanding of the world’ (Shaw 1999: 73). In this context Shaw believes a method can be developed to incorporate both research and evaluation into a single research design by avoiding the tendency to separate the terms because at first glance it appears appropriate to do so;

‘to talk of ‘evaluation research’... does make good sense, and involves no confusion of categories’ (Shaw 1999: 11).

Although the decision to include evaluation in my study was an epistemological one and decided as part of my research design, it was partly influenced by the requirements of co-funder CSCI, which meant there was initially outside pressure to incorporate an evaluative element to the research design. The CSCI had to be assured that they were to get something from the money they have invested in the research and although they were interested in the findings of the applied research, because of the nature of the organisation and the types of knowledge they are interested in, they were mainly interested in policy or practice outcomes.

Qualitative or quantitative method?

Form the initial stages of thinking about this research I always thought it likely that the primary research would involve mainly qualitative data. In chapter 3 I report a systematic review of international literature on the effectiveness of inspection, which I had hoped would have provided evidence as to *whether* inspection was effective at producing better outcomes for older people living in residential care. The plan was then to understand, in

detail, *how* the inspection process works, the positives and negatives of the intervention, and *how* it impacts on the stakeholders (residents, their family, staff, and manager). Although the systematic review unearthed no data on the effectiveness of inspection of older people's residential care, the primary research was still designed to focus on the ways in which inspection impacts on each case study site and discover the ways in which residents, staff, relatives and the care home management view as good quality care, if these views are similar and if they are the same as those the CSCI use to develop National Minimum Standards (NMS) for care homes (Department of Health 2001c).

Qualitative approaches can provide an understanding of causes and outcomes that sometimes may better answer the research question than conventional quantitative, comparison designed research. What is important is that the methods and research design are 'fit for purpose', and justified within this context (Shaw and Norton 2007). Shaw argues that qualitative research is important for facilitating the 'valuation of outcomes as opposed to the technicalisation of outcome research' (Shaw 2003: 72). By this he means that conventional views of outcome research tend to see outcomes as value-neutral and rational, for example in terms of health gain, when actually there are a range of political and social values that need to be considered (Shaw 2003). This is particularly relevant to the study of a regulator that measures outcomes for service users and tries to understand these outcomes in the context of their personal values.

In my case, the purpose is to try and understand and evaluate the impact of inspection and how this influences the quality of service and well-being of the residents. Qualitative methods appeared best suited to my design because I not only wanted to gain an understanding of the process but also wanted to understand the causal relationships of inspection and understand what factors influence the development of better quality care for older people in residential homes. In this sense I wanted my research to '...identify (causal) *mechanisms*, going beyond sheer association' (Miles and Huberman 1994: 147), to understand as well as identify causation.

Theoretical influences

Part of this research focuses on the perspectives of key stakeholders involved in the inspection of residential care for older people. A constructionist approach is sometimes

based on the concept of ontological relativity, which suggests that people's statements about reality and the world they live in are a local contingency of their worldview. While I support the idea that social processes are central to everyday life and that historical and cultural change influences people's value positions, I also agree that there is a need to ground critique and to understand continuity as well as variability. This position has led some theorists such as Campbell, House, Cook and Stake, to propose a realist ontology for social constructivism. Constructionism is not incompatible with realism:

'The essence of this position is that, although the real world, driven by real natural causes, exists, it is impossible for humans truly to perceive it with their imperfect sensory and intellectual mechanism' (Cook and Campbell 1979: 29)

A range of views exist within this critical realist position. Following this logic each of the stakeholders interviewed in my study will have different experiences and perceptions of inspection and what constitutes quality in the service they receive.

My theoretical approach is also influenced by the concept of 'symbolic interactionism' (Blumer 1969b) in the sense that perceptions of the stakeholders interviewed in this study may change as a result of interaction with inspection as it reformulates their world view and associations with what they see as 'quality' or 'good inspection'. Problems occur where there are imbalances of power and these multiple voices do not have an opportunity to be heard. This has particular salience for the evaluative part of my research because social care services and their regulation function on the premise of social justice and empowerment. A constructionist approach has influenced my thinking around this power relationship and in particular whether CSCI's inspection does actually reflect the experiences and perceptions of the people it is serving.

As Guba and Lincoln (1989) outline the researcher influenced by this approach must accept the existence of multiple realities and that knowledge is created by both the researcher and the researched (Guba and Lincoln 1989). In this sense it is important to be reflexive and acknowledge how one's own experiences influence the act of inquiry (Patton 2002). This was important in the analysis stage and in the following chapters I reflect on the influence of my experiences and theoretical thinking in relation to the data.

Credibility of qualitative research

Although qualitative research focuses on different methods of developing knowledge, which do not necessarily marry with techniques used to evaluate the quality of quantitative methods, I believe it is necessary to ensure as far as possible that the data collection and analysis of qualitative research is as robust and rigorous as possible. Patton (2002: 461) provides a useful set of checks that, if followed help to ensure research is credible. He defines credibility in qualitative research in terms of three distinct but related elements:

- Rigorous techniques and methods for gathering high quality data that is carefully analysed, with attention to issues of validity, reliability, and triangulation;
- The credibility of the researcher, which is dependent upon training, experience, track record, status, and presentation of self;
- Philosophical belief in the phenomenological paradigm, that is, a fundamental appreciation of naturalistic inquiry, qualitative methods, inductive analysis, and holistic thinking.

Throughout the design, data collection and data analysis stages of this work, I have attempted to address all three elements. Based on McCormick & James' (1988) suggestions for enhancing validity I have tried to incorporate the following measures at appropriate points:

Construct validity

- Using multiple sources of evidence in the data collection phase (interviews with inspectors, interviews with care home managers, interviews with care home residents, interviews with resident's friends and family, interviews with care home staff, observation with the care homes, analysis of inspection reports)
- Building uncertainty about inspection into the research design by testing individual's knowledge of the process before asking questions about it
- Using information from consultation with staff in CSCI and data from their records as key informants to enhance sampling validity

Internal validity

- Searching out cases that appeared at first glance to be contrary to my thinking or the consensus from other cases
- Being rigorous in the application of well defined data analysis techniques
- Pursuing alternative or rival explanations in the analysis of all data
- Using triangulation – of data collection *sources* and of *theories* in the data interpretation phases

External validity

- Collecting data from a variety of care home services in different areas of the country

Longitudinal approach

Although interest in this area is growing, there was only limited precedent for the longitudinal method in qualitative research at the time I commenced this study (Henwood and Lang 2003). Historically there has been considerable resistance in the quantitative research community to the value of longitudinal qualitative research, but Holland, Thomson et al (2006) found in their review for the ESRC that:

‘...some funders, government research managers and archivists suggest that there is in fact considerable support, and a clear scientific rationale for qualitative led or purely qualitative longitudinal research’ (Holland, Thomson et al 2006: 4)

The strength of the method in relation to the aims of my study is it allows me to document changes over time and evaluate the impact of inspection. The changes required or recommended after the inspection can only be implemented over a period of time and I wanted to examine both the process of implementing change, whether all changes in the period of study could be directly attributed to inspection, and how these changes (if they occurred) impacted on the stakeholders.

The case study method

The Case Study as a social science method is neither discreet nor defined. It is in essence the study of a ‘bound system’ – with the researcher looking for endogenous conclusions.

Platt (1981) traces the roots back to the social worker's 'case history' or 'case work', noting that social work case records were used in early studies that have since been heralded as classics of the method (e.g. Thomas and Znaniecki 1996). However, the use of the term is varied and often confused. Within academic research it is subject to 'conceptual stretching' and is often conflated with other methods such as ethnography, participant observation and qualitative research. It is also used in other areas such as law, medicine and social work in differing contexts. This multitude of uses means that as a method there is no universal set of criteria for its use and, as Hakim (2000) argues, case studies typically span a variety of methods and evidence.

To begin with I have to determine whether the area I am studying counts as a case. In order to be defined as a method of inquiry the case study must be defined, although as I have discussed others might use the term differently (e.g. a barrister might have a different interpretation to a social worker). Gomm, Hammersley and Foster (2000) identify two key dimensions crucial to any case study: first the number of cases being investigated, and second the amount of detailed information being collected. These two dimensions are relational because it is often the case that the fewer cases being investigated the more information can be collected in each case. A Case Study typically collects a large amount of data from each case, which spans a number of dimensions and different methods of collection. The unique strength of a case study is its ability to include a wide variety of evidence – documents, artefacts, interviews, surveys, observations – to build up a whole picture of the area being studied (Yin 2003). The cases I wanted to study were implicitly thought of as cases by the CSCI, who had an inspection record or 'case file' on each care home in England.

My case studies comprise a mixture of unstructured observation and semi-structured interviews, which leads to qualitative analysis of the data. Rather than aiming for generalisations I have instead aimed to understand the cases and make comparisons between them, although this provides insight into the impact of inspection in social care it does not provide any data that can be generalised to the rest of the residential care home population in England.

Although I will not be making generalisations, I agree with Robert Stake (Stake 1995) that case studies while not generalisable in a statistical sense can be used to make general

statements and provide insight beyond the cases themselves. I think this is particularly true of a case where a particular intervention is being studied. In this respect some of my findings will hopefully be transferable to other inspection situations and be illustrative, if not fully demonstrative, of inspection. Thus, results from this thesis will be generalisable to theoretical presuppositions and not a population as a whole. The goal of this thesis is to expand theories, not to identify frequencies. As Lipset, Trow and Coleman claim, ‘the goal is to do a generalising and not a particularising analysis’ (Lipset, et al. 1956: 419-420).

The implications for the findings of case studies depend on the type of study carried out. They can be restricted to description and explanation resulting in an in-depth understanding of the case or cases, or they can engage in some form of evaluation. The study I conducted looks at the ‘intervention’ of an inspection of four residential care homes for older people that were deemed previously by the regulator, CSCI, to be either performing poorly or adequately. The study examines how this intervention impacted on in the four homes, how and why it had this impact and how helpful it was in improving the performance of the home against the regulators standards, the study also examines whether the standards and indicators of quality used by the regulator match the opinions of particularly the residents in the homes, but also their relatives, the staff, and the care home management.

There was also a question over whether to consider individual or multiple cases. Multiple-case designs are preferred over single-case designs because, even with only a minimum of two cases there is a possibility of direct replication; analytical conclusions that are demonstrated as independently arising from two cases are obviously more powerful than those from a single case alone. It is also likely that two separate case-studies will have differing contexts and under these circumstances there is an immeasurably expanded possibility for external generalisation of the common findings, compared to a single case alone (Yin 2003).

RESEARCH DESIGN

In conjunction with CSCI I began the detailed planning of my research.

Purposive sampling

Developing the sampling and selection strategy is a very important strategic element of qualitative research. A sampling strategy provides the principles and procedures used to identify, choose and gain access to relevant units of study for data generation (Mason, 1996). To make sampling decisions that are 'fit for purpose' and reflect the theoretical underpinning of the study an appropriate relationship has been established between the selected sample and the exogenous world to which it is related. Therefore it is crucial to ensure that a sample of people is generated which consists of characteristics that are relevant to a combination of both the wider population (as representative of them as possible) and to the research questions. As previously discussed it is rare in qualitative research to use samples that are statistically representative of the population being studied. Rather it is appropriate to purposefully select a sample that is justified theoretically and best suits the aims of the study.

The sampling strategy that reflects this aim is known as *purposive* or *theoretical sampling*, which contrasts with statistical sampling that is used to generate empirically representative samples. It was felt that purposive rather than representative samples would be more appropriate for this study as the aim was not to be able to make wider generalisations but to deepen my understanding of a process of inspection, make a broad evaluation of each case, and provide insight into the process and outcomes of inspection. Using this purposive approach the emphasis is not on selecting a sample representative of the total empirical population, but on designing a sample that encapsulates a relevant range cases and experiences in relation to the wider universe (Mason, 1996). This enables the researcher to identify fundamental differences and similarities in conditions and provide an insight into the situations under which concepts and their properties vary.

Observation

The first stage of my data collection was observation of the inspection or 'event'. The inspection comprised a planning stage and site visit. The inspection was conducted in two stages: the planning and analysis of preliminary data and the site visit. In order to understand the planning stage I had a meeting with the inspectors the day prior to the respective inspections where they talked me through the planning of the inspection, explaining what they had done in preparation for the visit and how they used data received

prior to the visit to both influence their judgements and guide the site visit the following day. Observation of the site visit began when I met the inspectors at the case study service and followed the site visit. I was conscious of the 'Hawthorne effect' on both the inspector and the stakeholders in the service, but had to accept that this was an unavoidable limitation of the study. I was also conscious of my association with the inspector, particularly in the eyes of residents, but decided in the planning of this project that this organisational or insider status was similarly unavoidable and I used the first interview to clearly delineate my role and position as an independent researcher. I discuss my negotiation of the 'insider' / 'outsider' tightrope later in this chapter. I used observation throughout the case studies to supplement the interview data.

This was not an ethnographic study in the sense that observation was only one aspect of my data collection and I was guided by a pre-determined structure (Denzin 1970). The aim of this work is to find out about the consequences of inspection and then find out how and why inspection creates these outcomes. However, I was guided by many of the principles of ethnography in that I wanted to understand the viewpoint of stakeholders and the characteristics of interaction in relation to care services and inspection.

The aim of my observation was to gather first-hand information about social process in a 'naturally occurring' context, to identify primarily what the inspectors did when conducting the inspection and the ways that other stakeholders reacted to the inspection. In the words of Agar (1986) I was aiming to 'learn about a world... by encountering it firsthand and making some sense out of it' (Agar 1986: 12). The observational element of this research design allows me to examine the series of events that make up the process of inspection. It allows me to describe this process in detail and to help understand what is going on. When combined with data from interviews this provides clues to the impact the process has on stakeholders and provides useful data on 'what works' in the inspection process. Of course my observation would not be of a completely 'naturally occurring' context because my presence serves to change the dynamics of the inspection. I was interacting with the inspectors throughout the study and was asked my opinion on a number of occasions, which I always declined to give. The research was clearly influenced by my presence and my interaction with social processes. I recorded my observations both during the inspections and during my time spent in the services at the three data collection points.

Semi-structured interview

Following my observation of the inspection I conducted interviews at three separate data collection points. These were directly after the inspection, approximately eight weeks after inspection and then nine months after the inspection. The interviews were anywhere between 20 minutes and 90 minutes long and recorded on a digital recording device. Notes were also taken during the session. The use of a flexible interview schedule developed based on theoretical propositions developed from my planning, but with the flexibility to explore areas that were deemed interesting by the participants was the ideal way to answer my research questions.

Hammersley and Atkinson point out the distinction between reflexive (or semi structured interview) and standardised interviews (Hammersley and Atkinson 1983), the latter which only uses a standard set of questions which the interview does not deviate from and the former which is more flexible and allows probing and follow-up questions. I felt that a semi-structured interview incorporated the strengths of both interview strategies; allowing a degree of flexibility, while utilising the guiding influence that non-standardisation of questions bring to focus on inspection and the care home. Without a semi-structured schedule it is likely the respondents, especially the residents would have gone off on tangents. This tended to happen even with a semi-structured schedule. However, I also wanted to allow the participants' viewpoints to be expressed and give the respondents more freedom to elaborate on areas of the question he/she believed to be important. A semi-structured interview, while allowing me to address the questions developed during the research design, allows greater scope for the interviewee to express their own experiences and opinions, rather than being constrained by fixed standardised questions, which by virtue of their construction, constrain the participant's responses (Flick 2002).

Although I wanted to give the participants the opportunity to elaborate on their responses, as Schuman and Kalton identify 'a small change in the wording of a question can have a large effect on answers' (Schuman and Kalton 1998). Therefore, the questions and probes I used to address my initial theoretical presuppositions followed a standard wording, but presented the respondents with the opportunity to elaborate on their experiences and beliefs and respond to the question from their own perspective. By standardising the

wording all participants have the same stimuli from which to respond and their answers cannot be attributed to differences in questioning. I was also cautious of asking 'leading questions'. I am aware that there can be differing interpretations of the same question depending on the interviewees' background and the context of the interview. This was particularly pertinent as some interviews were with older people who were 50 to 60 years older than me. As such I adopted a process of 'meaning clarification' (Kvale 1996: 83) to provide a disambiguation of the statements made and during my analysis I was aware of the influence social context could have on answers to questions.

I employed a set of main questions in the interviews that were 'non-directive' (Rubin and Rubin 1995), to encourage maximum level of response from the interviewees. I wanted to allow them to elaborate on their expectations and attitudes to living in the care home, and inspection and explain their own interpretation of what factors they believed informed their opinions and thoughts on the case. I then followed these up with request for clarification or further elaboration, using unscripted questions to pursue answers already given.

These questions were 'probes' designed to stimulate further elaboration on issues that had already been brought up by the respondent. They were not used to refocus the data or influence the individual's answers in any way (Patton 1990). The purpose of deep probing of experiences, beliefs and attitudes in an interview situation is necessarily constructionist; the purpose is to elicit interpretations, not fact. It forces the participant to evaluate the interview process and could highlight events, circumstances and feelings the respondent had not considered before. In this situation, the interview itself is playing a role in the construction of the data by forcing a deeper consideration than has been required or attempted before. This 'active interview' situation has a role in making meaning and forces my reflection on my role as interviewer and acknowledgment that I play a role in the generation, rather than collection of the data (Mason 1996). Methodological literature places a great deal of emphasis on understanding the varied and often distinct perspectives of both the interviewer and respondent and these ideas will be discussed as I present my findings (Holstein and Gubrium 1995).

Interview themes

Based on my theoretical thinking stemming from my systematic review and further literature review, the themes I wanted to discuss in the interviews were as follows:

Residents

- Circumstance for being in care
- Choosing the service
- What constitutes well-being
- Feelings about being in care
- Quality of service – staff, food, environment, activities
- Daily activity and community involvement
- Views of inspection
- Questions developed specifically for each case study based on analysis of past reports

Managers and staff

- Views on their job
- Quality of service and management
- Time spent with residents
- Self-assessment
- Views on inspection
- Direct questions about the performance of the service and problems inspection might find
- Questions developed specifically for each case study based on analysis of past reports

Inspector

- Role
- Inspection process
- Performance of service
- Ambiguity-conflict matrix in their work (personalisation versus professionalisation)
- Routinisation
- Questions developed specifically for each case study based on analysis of past reports

The nature of the study meant I proposed to conduct 108 interviews over four case study sites. This posed a technical and theoretical problem in my approach to the interviews, which was particularly prominent for the interviews with residents. I was aware that residents might not have either the technical knowledge of the system, or the inclination to fully engage with direct questions about quality of care and inspection. In light of this I want to use questions about lived experience to create a picture of the residents' experiences and views about care. Although I tried to do this the interviews were necessarily more limited in scope than might have been possible using a more detailed approach that focused on residents. However, I believe my data provides insight into lived experiences from which I could reflect upon and draw conclusions about the impact of inspection (Van Manen 1992).

Documents

Documents provide a useful complement to the interview data and help triangulate the findings. They can be analysed quantitatively by, for example, looking at number of requirements, or they can be analysed qualitatively by looking at the content of the reports. I used the following documents and looked at their overall written assessment of the home:

- The three inspection reports published prior to the inspection I observed – to gain a history of the home and develop questions specific to the service and improvements CSCI would look at during the inspection I observed
- The inspection report published as a result of the inspection I observed

The reports were used in two stages. The first was as part of the study design process. I examined the three reports published prior to data collection to provide me with a background to the home and help me to develop specific questions for each service. These questions were specifically around improvements that had been made over the time prior to the data collection and to check that any outstanding improvements required or recommended in past reports had been carried out.

The second stage came during analysis. The reports gave me another way of understanding the perspective of the inspectors and discovering if their professional opinion, influenced by the organisational constraints and rules of writing the report, was similar to the one they

gave to me at the time of the inspection. In this sense I was aware that documents cannot be simply taken on 'face value' and read only for their content, it is necessary to understand how and why they are produced and the rules surrounding their production and use (Prior 2004). This was particularly relevant to my interviews with inspectors because I was able to examine the tensions between the official documentation and the views of the inspectors, contextualising their construction and purpose.

Choosing the case studies

Narrowing down the regions

I decided that for both practical and theoretical reasons I would use a purposive sample in my research. To determine this sample I discussed the suitability with members of CSCI's Methodology and Policy team and decided that in order for my study to develop broad and illuminating examples I should refrain from limiting my sample to one council area or even one regional area (Hakim 2000). Contacts at the CSCI thought there were still a lot of local differences between inspection teams and even inspection regions so it would be best to sample at least two different regions. Restricting my sample to one region, even if I opted for diversity within that region would be unnecessarily restrictive, therefore I opted for two regions, one in the south and one in the north, in order to reflect north-south variation. It was decided, after consultation with Information and Knowledge Management at CSCI, that the North East and Eastern regions were suitable candidates. They cover the range of types and quality of homes. From a practical perspective both regions although heterogeneous are reasonably small geographically, which means that it will be relatively easy to access a diverse sample (as opposed to, for example, the sparse South West, which would provide difficulties in travelling around).

Choosing how to collect the data

This is a longitudinal study over nine months, during which time I interviewed nine participants on three occasions and the inspector of each case study service. I interviewed the following people in each study:

- 3 residents at each case study site
- 1 member of each of the 3 resident's family/ friend

- The registered manager at each case-study site
- 2 staff members in each home
- The inspector of the home (this will only take place once, after the initial inspection)

I also used the following data to supplement the interviews:

- 3 inspection reports published prior to the inspection I am observing – to gain a history of the home and develop questions specific to the service and improvements CSCI will be looking during the inspection I am observing
- the inspection report published as a result of the inspection I am observing
- my notes based on observation of the inspection I followed
- observation conducted during my time spent in the home at the three points in time

Having initially planned to study six case studies at three points in time I decided to reduce this to four after calculating the amount of data I would collect if I stuck to six. Bearing in mind this was only the first (although larger) part of the study I decided that six sites would be unmanageable in-terms of both collecting and analysing the data.

Table 5: Potential number versus actual number of interviews

| | No. of interviews with 6 sites at three separate points in time | No. of interviews with 4 sites at three separate points in time |
|--------------|---|---|
| 3 residents | $3 \times 3 = 9$ (x 6 sites) = 51 | $3 \times 3 = 9$ (x 4 sites) = 36 |
| 3 F&F | $3 \times 3 = 9$ (x 6 sites) = 51 | $3 \times 3 = 9$ (x 4 sites) = 36 |
| 2 staff | $2 \times 3 = 6$ (x 6 sites) = 36 | $2 \times 3 = 6$ (x 4 sites) = 24 |
| 1 manager | $1 \times 3 = 3$ (x 6 sites) = 18 | $1 \times 3 = 3$ (x 4 sites) = 12 |
| 1 inspector | 1 (x 6 sites) = 6 | 1 (x 4 sites) = 4 |
| Total | 162 | 112 |

As the table above shows even conducting four case studies longitudinally over 3 points time led to 112 interviews and to have conducted the study over six sites would have meant an unmanageable 162 interviews.

Deciding to conduct only four rather than six case studies posed a problem for my research design, as I had planned to study two cases at each of the three internal rating levels the CSCI had at the time of my data collection. Before the current star rating system, introduced in January 2008, CSCI had internal ratings for each service, based on their

inspection and report. I had planned to use these ratings and study two poor, two adequate and two good services, as judged by CSCI after the previous inspection (which would have been a maximum of one year prior to the inspection I was shadowing) of each service. Having decided that four case studies were appropriate I then concluded that in terms of the aims of my study it would be best to focus on services at the poorer end of the internal ratings spectrum. This is because the various inspectors I spoke with during the development stage of the study hypothesised that inspection would have more impact on these cases and they would therefore be more appropriate to discover how the intervention affects the home.

Number of interviews: the impact of attrition

The levels of dependency and unwillingness of one or two residents to be involved in the study meant that in the first case study (CH1) only two residents were interviewed directly and one daughter provided interviews on behalf of her mother. In case study three (CH 3) it proved difficult to get relatives to agree to participate, which meant I only managed to interview one relative on all three occasions and a second during the second and third data collection points. In both the second (CH 2) and fourth case (CH 4) studies a resident died in the six-month gap in-between the second and third points of data collection and so final interviews them and their relatives could not be conducted.

Recruiting participants and gaining consent

Gaining permission from relevant case study homes

The participant homes were identified in conjunction with the Commission for Social Care Inspection (CSCI). I liaised with an inspector in each of four local offices across two regions. The CSCI divides England into nine administrative regions and in consultation with CSCI I decided that a purposive sample of two of these regions would be most appropriate. Having decide to narrow down my sample from six to four sites I decided to sampled two services judged as level 1 (i.e. failing against a number of NMS) and two as level 2 (narrowly failing to meet a number of NMS), one of each level in the two regions, omitting the level 3 homes all together.

Two prospective homes were identified, a first and second choice. Initial contact was made by letter, or where agreed with the relevant inspector an informal phone call from the inspector to gain preliminary permission (after which a letter from me was sent). The letter was then followed by a phone call approximately two weeks after posting, to get initial reaction and arrange a meeting to explain the project further, answer any questions and gain permission. If permission was declined I would then have contacted the second home (and subsequent homes if necessary) using the same process. However, because this study is part sponsored by the CSCI and I had contact with the inspectors of each service, they were all happy to take part.

I was very careful to explain that this research was independent from the CSCI and that I was in no way influenced by their actions or judgement. I also was very explicit with each manager about his or her right to refuse to be part of the study, and that this decision would have no bearing on the outcome of the CSCI inspection. I made this explicit in my initial contact letter and when I met the manager for the first time I ensured I pointed this out; giving them the option to refuse to take part. Having taken pains to make this one or two of the managers were still conscious of my working relationship with the CSCI and were swayed by my perceived 'insider' status within the organisation. Although this perception was initially useful in terms of recruiting my sample, I wanted to shake this tag before the first part of my data collection, to ensure the participants would be open and honest with me without thinking I would pass things on to the inspector, or pass judgement on the home myself. To assert my independence from CSCI I conducted a second meeting with each service to further explain my research to the manager.

Informed consent by participants

I only interviewed individuals once consent had been given, as required by both the University of York Ethics Committee and the Association of Directors of Social Services (ADASS) approval board. I agree that consent is a necessary feature of research, especially where gaining it will not compromise the fundamental design of the study. Allmark (2002) suggests that informed consent should adhere to the following criteria:

- The consent should be given by someone competent to do so;
- The person giving consent should be adequately informed;

- The consent is given voluntarily. (Allmark 2002)

Following these criteria I decided that consent could be given in one of two ways; either by reading and signing a letter of participation, or giving consent on the recording. Giving consent onto the recording gave individuals who were wary of putting their name to official documentation the chance to consent anonymously; in this case they were only identified on the recording by their interview number. The option to consent in this manner also gave frail residents who could not write the chance to consent.

I ensured participants were satisfied they knew enough about the purpose of my research by giving them a brief information sheet about the project and answering any initial questions. This was a requirement of the ethics committee and although I wanted to ensure the participants knew that they were taking part in a research project and that it was in relation to a government regulator I wanted to avoid giving the respondents too much information that might influence or bias their responses to my questions. As I did not interview any participants with dementia there were no concerns about participants being too vulnerable to give informed consent.

Participants were free to end their participation in the research at any time, at which point I would have either cease the interview, or if they data has already been collected, cease using it and remove any reference to this data from any reporting. None of my participants requested this option, either during the data collection or subsequently.

Negotiating the ‘insider’ / ‘outsider’ tightrope

This research presented me with an interesting dilemma regarding my ‘insider’ / ‘outsider’ status because it was necessary to juggle this conundrum across two organisations – the CSCI and the service I was studying. Adler and Adler talk of social groups as frequently having ‘two sets of realities about their activities: one presented to outsiders and the other reserved for insiders’ (Alder and Alder 1987: 21). The aim of my research was to get beyond the exterior presentation and understand both inspection and the functioning of the home from the insider. As I discuss above, regarding perceptions of managers, there were some aspects of attempting to be an ‘insider’ across two conflicting organisations that were problematic. My strategy was to gradually move from being a simple ‘visitor’ to the home

and relying solely on my research questions, to becoming, as far as possible, an ‘initiate’ (Flick 2006). To do this I had to persuade the care home staff and residents that I was not an inspector, as some initially thought when I arrived with the inspector to shadow their inspection. To achieve this I spent my first day in each service, after I had shadowed the inspection the previous day, chatting with people informally to assure them of my role as a researcher independent from the CSCI. It also helped me to begin to understand the staffs’ viewpoints and the organisational principles of the groups. I was not conducting an ethnographic study and only spent five days in each service, three times in a nine month period. So I cannot claim to have developed a true ‘initiate’ position, but this informal conversation and observation, supported by field notes, did provide an extra dimension of insight into the cases I was studying.

I was also aware of what Adler and Adler term ‘the two sets of realities’ that exist in research – the reality presented to you as a researcher and the reality kept hidden, even if you become fully integrated into the field (Adler and Adler 1987) . These are areas that will only be accessible if researchers conceal from the field their role as researchers, an option that was not ethically or practically viable in this research. This point was especially pertinent during my research because the majority of participants first saw me with the inspector carrying out an inspection. This inevitably increased the perception of some that I could pass on information that could result in negative consequences, no matter how much I emphasised my independence (Flick 2006). I reflect on this within my research findings.

ETHICAL CONSIDERATIONS

See Appendix 5.

ANALYSIS

Analytical framework

I looked at the causes and consequences of inspection, with emphasis on not only ‘what’ works, but ‘how’ and ‘why’ it works. To do this I will use my notes from observation during the day of the inspection, observation in the home at the subsequent data collection

points and interviews with all stakeholders. With these broad aims I also examined the interplay between individual change and change within institutions and social structures.

Analytical technique

‘Qualitative analysis transforms data into findings. No formula exists for that transformation’ (Patton 2002: 432)

As Patton succinctly claims in the above quote there are numerous different ways to analyse qualitative data, each with often only subtle differences from the last. Because there are no commonly agreed rules the ‘skill, knowledge, creativity and diligence’ (Patton 2002: 432) of the analyst is extremely important. The aims of my research – to explore both the impact of inspection and evaluate the process - suggest that both coding of themes or concepts and analysis of narrative are useful analytical techniques. I developed a theoretical framework through which I analysed my data:

Understanding the *process* focused on gaining an insight into the function of inspection. This involved examine the technical aspects of the process and the rationale for approaches used. It also focused on any tensions that might exist at the professional level between organisational direction and professional discretion / judgement.

Individual change focused on individual contact with inspection and how it is experienced. Analysis explored: whether their understanding of inspection develops over time; the development of their personal life and lived experience over the 3 data collection points (including health issues); the development of residents’ relationship with staff; the development of relationships between staff; the development of relationships between staff and the management.

Service change focused on changes in the delivery process. This involved understanding how the service was reviewed and changed and whether these changes, if any, can be attributed to inspection, or indeed other factors. The specific focus of analysis was on:

- The dynamic of the service – whether this has changed and how
- What works in terms of inspection

- How this service change, if it occurred, impact on service users (using cross referencing between themes)

Policy domain and structural changes to inspection – Due to the evolving nature of the inspection regime I was conscious of any changes in policy and practice of inspection during the nine month study and see if any changes occurred and if so what impact these changes had. I did this by reviewing CSCI and government literature and cross-referencing any changes with evidence of their impact on the sample care homes.

As I have explained I found it appropriate in the context of this research that there should be a strong analytical foundation based on theoretical propositions developed during the research design and literature review period; it seems sensible to ensure that when developing materials and interview schedules for data collection that these should be based on a strongly developed theoretical question and situated within the findings of others who have worked in the same field. It think this holds even more true for research that includes an evaluative element and used both techniques during analysis.

Transcription

Transcription was conducted both onto a computer file and by hand. The fact that some transcription was conducted by hand meant a Computer Aided Qualitative Data Analysis Software (CAQDAS) programme was not used for analysis. I choose to utilise a technique of colour coding using highlighters and post-it notes as I found this to be a more tactile technique than the technical constraints of a CAQDAS programme. In taking this decision I took inspiration from Coffey and Atkinson who claim: ‘the important analytical work lies in establishing and thinking about the linkages, not the mundane process of coding’ (Coffey and Atkinson 1996: 27)

Coding

Miles and Huberman (1996) describe codes as tags attached to chunks of data. They are essentially labels to describe what the data means or to represent meanings inferred to the data by researchers. In this sense codes can either be used to manage data, by simplifying

them into segments, or to expand and interpret the data by inferring context and meaning to the codes (Denzin and Lincoln 1998).

Coffey and Atkinson (1996) argue that codes can be either created before the data collection begins, based on the theoretical framework that influences your research design or they can be developed inductively from the data (Coffey and Atkinson 1996). I agree with Strauss (1987) that coding is more than just a procedural process for indexing and sorting data, that it is about conceptualising the data, or to put it into his words ‘breaking it apart’ (Strauss 1987: 292). Coding is a way of relating data to the researchers’ ideas about those data; it provides a system of links between specific parts of the data and concepts or ideas. However, as Coffey and Atkinson caution ‘one should not confuse coding itself with the analytical work of developing conceptual schemes’ (Coffey and Atkinson 1996: 27). Coding is organisational in one sense, in that it allows the researcher to distinguish between and combine data, but it is also involves conceptualising the data by developing concepts and themes and incorporating reflections.

I designed my research based on a set of objectives, which were subsequently developed as a result of my literature review and systematic review. Propositions stated at the beginning of the research are incorporated into the design of the study to focus the analysis on certain data relating to aims and research questions; however they can often cause bias by focusing the researcher on certain parts of the data. In order to properly test the propositions it is necessary to also examine the possibility of rival explanations: that observed outcomes were the result of some other influence besides the intervention (inspection by CSCI). It is important to search for these rival explanations and collect as much evidence as possible about other influences. Robert Yin states that in order to ensure analysis is not biased by theoretical propositions it is important to go further than simply looking for rival explanations, he feels it is necessary to have ‘...pursued your data collection about them vigorously – as if you were in fact trying to prove the salience of the other influence’ (Yin 2003: 112). Therefore my approach was to analyse the data with my pre-existing questions and themes in mind but also remain perceptive to new ones.

To achieve a balance between pre-existing and new themes I conducted a combination coding process, with two strands:

1. Understanding the individual cases and comparing them to one another to find both *intra* case and *inter* case themes and patterns, e.g. in what ways did inspection improve well-being for residents
2. Gaining insight into wider issues, such as whether inspection actually works to improve services both in terms of the inspectorates own evaluation of performance but also the opinions of the other stakeholders, and discover whether these opinions tally.

A combination analysis like this one allowed the flexibility and knowledge development properties of open coding to complement and develop the theoretical propositions made prior to the data collection.

By combining the theoretical propositions and themes developed through open coding will hopefully provide an insight into other cases and inspection in general, allowing me to understand and evaluate the cases I am studying, as well as gain an insight into issues about the impact of inspection on stakeholders.

Analysing narratives: A thematic approach

In order to avoid being hoist by my own petard and losing sight of the totality of individual's stories by segmenting my analysis into codes, I also used narrative analysis to understand the sense of identity, and participant's conceptualisation of the issues being studied, such as their opinion on what constitutes good quality care and inspection. Rather than conducting full narrative analysis my focus was on the content of the interview and the participants' 'suppositions about what can be taken as expected, what the norms are, and what common or special belief systems can be used to establish coherence' (Linde 1993: 3). I have been influenced by the work of Riessman, who has incorporated thematic analysis into the narrative method. Narrative analysis of this type focuses on the participants' reports of events and experiences, rather than how they tell the story. As Riessman explains:

'This means there is minimal focus on *how* narrative is spoken, on structures of speech a narrator selects, audience (real and imagined), the local context that generated the narrative, or complexities of transcription' (Riessman 2008: 54).

Focusing on narratives within interviewees speech help me understand how they were conceptualising the issues I was identifying and studying.

Using this hybrid method allowed me to bridge the gap between two often distinct methods and take the best from both: coding, which facilitates systematic focus and organisation, but which inevitably cuts the data into 'chunks' and analysing the whole narrative of the interview to understand the issues under study.

CONCLUSION

This chapter has described the development of my research methodology. I conducted a qualitative study based on the analysis of four cases studies, each examined longitudinally over a nine month data collection period. I have examined the impact of inspection from the perspective of the inspectors themselves and the other key stakeholders within older peoples' residential care: the residents, relatives, the care home manager and the care home staff. The proceeding analytical chapters will not only detail the themes drawn from my analysis of the data but will also include my reflections on the methodological process and discuss some of the issues raised in this chapter.

CHAPTER 4: 'THE EVENT'

INTRODUCTION

This chapter focuses on a description of the 'event' of inspection and aims to give the reader a picture of the process. The chapter draws on data from my observations of each case study, as well as interviews with the inspector, manager of the service, residents, relatives and staff. The interview data comes mainly from the section of the interviews where I discussed experiences of inspection. It also draws on CSCI documents to develop a picture of the organisational framework, which guides the inspection process and compares this to the experiences of the stakeholders involved in each case study.

The chapter includes some discussion of issues raised around the impact of inspection on quality of service that will be discussed in more detail in the following chapters, where links will be made.

Any form of inspection that focuses on outcomes and standards that cannot be measured through the collection of quantitative data must tread a tightrope between organisational procedures (developed in order to achieve consistency of judgement), and the use of professional judgement by the inspectors. This relationship between the standardisation of inspection procedure, developed and implemented through training and organisational prescription (in the form of guidelines), and the individual workings of the individual inspector developed through years of professional, tacit experience forms the key to understanding the inspection process. By examining the day-to-day working of each inspector, how they encounter and solve problems and how they respond to new organisational initiatives, I hope to develop a clearer picture of the purpose and achievements of inspection.

THE CASE STUDY SITES

Before I discuss the main findings it is necessary to describe the case study sites in which the inspections took place. In this section I present analysis of the NMS scores from the three reports previous to the inspection I observed. I do this to provide context to my case

studies and to examine the previous impact inspection has had on the home as judged against the CSCI's NMS. Looking at past impact has a substantive analytical value in that it gives an idea of the historical effectiveness of inspection as judged against the CSCI's own metrics. It also provides context for my analysis of the case studies by showing how the services previously reacted to inspection. These data offer context in the form of inspectors' prior 'knowledge' of the services – i.e. as an element in understanding the background of the service. This then feeds into the way they conduct the observed inspection.

Case study 1: Inspection April 2007

Care Home 1 (CH 1) is a medium-size (10 to 30 bed) service in a small village situated just outside a medium sized city in the south of England. It is an independent family owned and run home.

A single inspector conducted the inspection over two days. A second day was required because the manager was absent on the first day and the majority of the paperwork was locked away.

I interviewed the inspector directly following the inspection and then the following stakeholders at 3 points during the eight-month case study:

Table 6: Interviews conducted during Case Study 1 (CH 1)

| | Interview point | | | | Interview point | | | | Interview point | | | | Interview point | | |
|----------|-----------------|---|---|----------------|-----------------|---|---|----------------|-----------------|---|---|-------------|-----------------|---|---|
| | 1 | 2 | 3 | | 1 | 2 | 3 | | 1 | 2 | 3 | | 1 | 2 | 3 |
| Manager | x | x | x | Resident 1 (m) | x | x | x | Relative 1 (f) | x | x | x | Staff 1 (f) | x | x | x |
| Co-owner | x | x | x | Resident 2 (f) | x | x | x | Relative 2 (f) | x | x | x | Staff 2* | x | | x |
| | | | | Resident 3 (f) | | | | Relative 3 (f) | x | x | x | Staff 3 (f) | x | x | x |

* Staff 2 was absent during second interview

Although this service was, like the other 3 sites, registered as a Care Home only with no dementia beds, the dependency levels of residents in this service appeared to be greater than residents in the other 3 services. Residents with very high levels of dependency - who

needed hoists to be moved, or who, to an untrained observer, have communication difficulties - appeared to be in the majority at this site, in comparison to the minority at the other sites.

Table 7: NMS scores CH 1

Highlighted column represent the NMS scores and report outcomes from the inspection I observed.

| NMS | Report: 01/2006 | Report: 05/2006 | Report: 12/2006 | Report: 04/2007 | Outcome ratings from case-study inspection | Overall score from case-study inspection | |
|-----|-----------------|-----------------|-----------------|-----------------|--|--|-------------------------------------|
| 1 | | | | | Choice of home (1-6): Good | Poor | |
| 2 | 3 | | | | | | |
| 3 | 1 | 3 | 3 | 3 | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | 1 | 3 | 3 | | | | |
| 7 | 2 | 2 | 2 | 2 | Health and personal care (7-11): Adequate | | |
| 8 | 2 | 3 | 3 | 3 | | | |
| 9 | 3 | | 1 | 2 | | | |
| 10 | 3 | | 3 | 1 | | | |
| 11 | | | | | | | |
| 12 | 3 | | 1 | 1 | Daily life and social activities (12-15): Poor | | |
| 13 | 3 | | 3 | 3 | | | |
| 14 | 3 | | 3 | 3 | | | |
| 15 | 3 | | 2 | 2 | | | |
| 16 | 3 | | 2 | 2 | | | |
| 17 | | | | | Complaints and protection (16-18): Adequate | | |
| 18 | 1 | 2 | 2 | 3 | | | |
| 19 | | 3 | 3 | 3 | | | Environment (19-26): Good |
| 20 | 4 | | | | | | |
| 21 | | | | | | | |
| 22 | | | | | | | |
| 23 | | | | | | | |
| 24 | | | | | | | |
| 25 | | | | | | | |
| 26 | 3 | | 3 | 3 | | | |
| 27 | 3 | | 2 | 2 | Staffing (27-30): Poor | | |
| 28 | 1 | 2 | 1 | 2 | | | |
| 29 | 1 | 2 | 1 | 2 | | | |
| 30 | | 2 | 2 | 2 | | | |
| 31 | 1 | 1 | 1 | 2 | Management and administration (31-38): Poor | | |
| 32 | | | 2 | 2 | | | |
| 33 | | 1 | 2 | 2 | | | |
| 34 | | | | | | | |
| 35 | | 3 | | | | | |
| 36 | 1 | 1 | 2 | 2 | | | |
| 37 | | | | | | | |
| 38 | 1 | 2 | 3 | 3 | | | |

Scoring: 4 = Standard Exceeded (Commendable) 3 = Standard Met (No Shortfalls)
2 = Standard Almost Met (Minor Shortfalls) 1 = Standard Not Met (Major Shortfalls)

The NMS scores for CH 1 (Table 7) show that inspection has induced small quality improvements since January 2006, especially in outcome areas rated as 'poor', where there was a stepwise increase from major shortfalls against particular standards to minor shortfalls. However, despite these small improvements the service has historically performed poorly against the key outcome areas of 'Management and Administration', 'Daily Life and Social Activities' and 'Staffing'. The slow progress is problematic because despite slight improvements the management appears unable to raise the performance of the service to meet all of the standards. The lack of improvement demonstrates the CSCI have failed to implement an effective strategy to induce improvement and clearly the punitive sanction of issuing a poor report is not working.

Case study 2: Inspection April 2007

Care Home 2 (CH 2) is a mid-size home in a medium sized city in the south of England. It is part of a larger organisation and the manager has support from / is accountable to an area manager (or equivalent).

The inspection was conducted by three inspectors during a single morning. The inspectors comprised: the primary inspector of the home, the Regulation Manager (RM), and a pharmacist inspector.

The RM is the person responsible for planning and overseeing the inspection of all services that fall within the boundaries of their office. In this case study the RM had a policy that she would try to accompany inspectors on visits to level 1 services, where possible. She explained a two-fold reason for this:

'It's to both drive home the fact that they need to improve and if they don't things could get serious and also to support the inspector, because often the level 1 services can be a very time consuming inspection with lots of niggly bits... as it happens this one had improved quite a bit and it wasn't so bad.' (RM, CH 1)

The pharmacist inspector was asked to come along because there was a serious failing in medication procedure at the time of the last inspection and the inspector and RM wanted to ensure this was properly checked.

I interviewed the inspector and Regulation Manager (RM) directly following the inspection and then the following stakeholders at 3 points during the eight-month case study:

Table 8: Interviews conducted during Case Study 2 (CH 2)

| | Interview point | | | | Interview point | | | | Interview point | | | | Interview point | | |
|------------------------|-----------------|---|---|----------------|-----------------|---|---|----------------|-----------------|---|---|-------------|-----------------|---|---|
| | 1 | 2 | 3 | | 1 | 2 | 3 | | 1 | 2 | 3 | | 1 | 2 | 3 |
| Manager | x | x | * | Resident 1 (f) | x | x | x | Relative 1 (m) | x | x | x | Staff 1 (f) | x | x | x |
| Manager's Line Manager | x | x | x | Resident 2 (f) | x | x | + | Relative 2 (m) | x | x | | Staff 2 (f) | x | x | x |
| | | | | Resident 3 (m) | x | x | x | Relative 3 (f) | x | x | x | Staff 3 (f) | x | x | ~ |

* Manager on long-term absence so her Line Manager (who was responsible of 6 homes in the region) had took over management duties.

+ Resident died

~ Staff member had left the home

Table 9: NMS scores CH 2

Highlighted column represent the NMS scores and report outcomes from the inspection I observed.

| NMS | Report: 02/ 2006 | Report: 07/ 2006 | Report: 11/ 2006 | Report: 4/ 2007 | Outcome ratings from case-study inspection | Overall score from case-study inspection |
|-----|------------------------|------------------------|------------------------|-----------------------|--|---|
| 1 | | 3 | 3 | 3 | Choice of home (1-6): Good | Adequate – the adequate rating from health an personal care reflected poor medication practice, which meant that despite improvements elsewhere the service could only achieve an adequate score |
| 2 | 3 | | 3 | 3 | | |
| 3 | 3 | 3 | 3 | 3 | | |
| 4 | 3 | | 1 | 3 | | |
| 5 | 3 | 3 | | | | |
| 6 | | | | | | |
| 7 | 2 | 2 | 2 | 2 | Health and personal care (7-11): Adequate | |
| 8 | 3 | 3 | 1 | 3 | | |
| 9 | 2 | 2 | 1 | 2 | | |
| 10 | 3 | 3 | 1 | 4 | | |
| 11 | | | | | | |
| 12 | 3 | 2 | 1 | 3 | Daily life and social activities (12-15): Good | |
| 13 | 3 | 3 | 3 | 3 | | |
| 14 | 3 | 3 | 3 | 3 | | |
| 15 | 3 | 3 | 2 | 3 | | |
| 16 | 3 | 3 | 3 | 3 | | |
| 17 | | | | | Complaints and protection (16- 18): Good | |
| 18 | 3 | 3 | 3 | 3 | | |
| 19 | 3 | 3 | 3 | 3 | | |
| 20 | 3 | 3 | | | Environment (19-26): Good | |
| 21 | 3 | | | | | |
| 22 | 3 | 3 | | 3 | | |
| 23 | 3 | 3 | | | | |
| 24 | 3 | | | 3 | | |
| 25 | 3 | 3 | | | | |
| 26 | 3 | 2 | 2 | 3 | | |
| 27 | 3 | 2 | 2 | 3 | | |
| 28 | | 3 | 3 | 3 | Staffing (27-30): Good | |
| 29 | 3 | 3 | 3 | 3 | | |
| 30 | 3 | 3 | 2 | 3 | | |
| 31 | 3 | 3 | 2 | 3 | | |
| 32 | | 3 | | | Management and administration (31-38): Adequate | |
| 33 | 3 | 3 | 2 | 3 | | |
| 34 | | | | | | |
| 35 | 3 | 3 | 3 | 3 | | |
| 36 | 3 | 1 | | 3 | | |
| 37 | | | | | | |
| 38 | 2 | 3 | 1 | 2 | | |

Scoring: 4 = Standard Exceeded (Commendable) 3 = Standard Met (No Shortfalls)
2 = Standard Almost Met (Minor Shortfalls) 1 = Standard Not Met (Major Shortfalls)

From the inspection in November 2006 to the one I observed in April 2007 CH 2 showed improvement in all seven CSCI outcome areas. There was improvement across most of the standards inspected and no decreases in score against any of the standards. The table shows that scoring against the NMS returned to a slightly higher, but similar, level to the July 2006 inspection, supporting the manager’s assertion that the November 2006 inspection was a ‘blip’ that occurred as a result of a combination of the manager being on long term sick leave and a number of agency staff being on duty because of staff sickness.

Case study 3: Inspection May 2007

Care Home 3 (CH 3) is medium-size service in a small town in the north of England. It is an independent family owned and run home.

A single inspector conducted the inspection in one day.

I interviewed the inspector directly following the inspection and then the following stakeholders at 3 points during the eight-month case study:

Table 10: Interviews conducted during Case Study 3 (CH 3)

| | Interview point | | | | Interview point | | | | Interview point | | | | Interview point | | |
|---------|-----------------|---|---|----------------|-----------------|---|---|----------------|-----------------|---|---|-------------|-----------------|---|---|
| | 1 | 2 | 3 | | 1 | 2 | 3 | | 1 | 2 | 3 | | 1 | 2 | 3 |
| Manager | x | x | x | Resident 1 (f) | x | x | x | Relative 1 (m) | x | x | x | Staff 1 (f) | x | x | x |
| | | | | Resident 2 (f) | x | x | x | Relative 2 (m) | * | x | x | Staff 2 (f) | x | x | x |
| | | | | Resident 3 (f) | x | x | x | Relative 3 + | | | | Staff 3 (f) | x | x | x |

* Relative not available during first data collection point

+ Could not get third relative to participate

Table: 11 NMS scores CH 3

Highlighted column represent the NMS scores and report outcomes from the inspection I observed.

| NMS | Report: 04/2005 | Report: 11/2005 | Report: 05/2006 | Report: 05/2007 | Outcome ratings from case-study inspection | Overall score from case-study inspection |
|-----|-----------------|-----------------|-----------------|-----------------|---|---|
| 1 | 3 | | 3 | | Choice of home (1-6): Good | Adequate – the adequate rating from management and admin. reflected manager’s lack of qualifications, which meant they service could only achieve and adequate score |
| 2 | 2 | 3 | 3 | | | |
| 3 | 3 | | 2 | 3 | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | 1 | 3 | 2 | 3 | Health and personal care (7-11): Good | |
| 8 | 2 | | 3 | 3 | | |
| 9 | 1 | 3 | 2 | 3 | | |
| 10 | 3 | | 3 | 3 | | |
| 11 | | | | | | |
| 12 | 2 | 2 | 2 | 2 | Daily life and social activities (12-15): Good | |
| 13 | 3 | | 3 | 3 | | |
| 14 | 3 | | 3 | 3 | | |
| 15 | 2 | 3 | 3 | 3 | | |
| 16 | | 3 | 2 | 2 | Complaints and protection (16-18): Good | |
| 17 | | | | | | |
| 18 | 1 | 2 | 2 | 3 | | |
| 19 | 2 | 3 | 2 | 2 | Environment (19-26): Adequate | |
| 20 | 3 | 3 | | | | |
| 21 | 1 | 3 | | | | |
| 22 | 2 | 3 | | | | |
| 23 | 3 | 3 | | | | |
| 24 | 3 | 3 | | | | |
| 25 | 1 | 3 | | | | |
| 26 | 3 | | 2 | 3 | | |
| 27 | 1 | 3 | 2 | 3 | Staffing (27-30): Good | |
| 28 | | 3 | 3 | 3 | | |
| 29 | 1 | 2 | 2 | 3 | | |
| 30 | 2 | | 3 | 2 | | |
| 31 | | 2 | 2 | 2 | Management and administration (31-38): Adequate | |
| 32 | | | | | | |
| 33 | 2 | 2 | 2 | 3 | | |
| 34 | 2 | 2 | | | | |
| 35 | | 3 | 3 | 3 | | |
| 36 | | | | | | |
| 37 | | | | | | |
| 38 | | 2 | 2 | 3 | | |

Scoring:

4 = Standard Exceeded (Commendable) 3 = Standard Met (No Shortfalls)

2 = Standard Almost Met (Minor Shortfalls) 1 = Standard Not Met (Major Shortfalls)

The NMS scores from the inspection of CH 3 in May 2007, show some improvement from the previous inspection with only standard 30 being scored lower than previously and the rest either showing no change or a shift from level 2 (standard almost met) to level 3 (standard met). Of the seven outcome areas the report is broken down into only two were judged to be adequate, while five were rated as good, yet the service was still only given an internal overall rating of adequate.

Case study 4: Inspection May 2007

Care Home 4 (CH 4) is a large service (over 30 beds) in a medium size city in the north of England. It is part of a larger organisation and the manager has support from / is accountable to an area manager (or equivalent).

A single inspector conducted the inspection in one day.

I interviewed the inspector directly following the inspection and then the following stakeholders at 3 points during the eight-month case study:

Table 12: Interviews conducted during Case Study 4 (CH4)

| | Interview point | | | | Interview point | | | | Interview point | | | | Interview point | | |
|---------|-----------------|---|---|----------------|-----------------|---|---|----------------|-----------------|---|---|-------------|-----------------|---|---|
| | 1 | 2 | 3 | | 1 | 2 | 3 | | 1 | 2 | 3 | | 1 | 2 | 3 |
| Manager | x | x | x | Resident 1 (f) | x | x | x | Relative 1 (m) | x | x | x | Staff 1 (f) | x | x | x |
| | | | | Resident 2 (f) | x | x | * | Relative 2 (m) | x | x | | Staff 2 (f) | x | x | x |
| | | | | Resident 3 (m) | x | x | x | Relative 3 (f) | x | x | x | Staff 3 (f) | x | x | x |

* Resident died

Table 13: NMS scores CH 4

Highlighted column represent the NMS scores and report outcomes from the inspection I observed.

| NMS | Report: 05/2005 | Report: 10/2005 | Report: 05/2006 | Report: 05/2007 | Outcome ratings from case-study inspection | Overall score from case-study inspection |
|-----|-----------------|-----------------|-----------------|-----------------|---|---|
| 1 | 3 | 3 | | | Choice of home (1-6): Good | Adequate – the adequate rating for management and admin. reflected lack of maintenance certificates and poor fire safety practice, which meant they service could only achieve an adequate score |
| 2 | 3 | | 2 | 2 | | |
| 3 | 2 | 2 | 3 | 3 | | |
| 4 | 2 | 2 | 3 | | | |
| 5 | | 3 | | | | |
| 6 | | | | | | |
| 7 | 2 | 2 | 2 | 3 | Health and personal care (7-11): Good | |
| 8 | 2 | 2 | 3 | 3 | | |
| 9 | 1 | 3 | 2 | 3 | | |
| 10 | 3 | | 3 | 3 | | |
| 11 | 3 | | | | | |
| 12 | | 3 | 1 | 3 | Daily life and social activities (12-15): Good | |
| 13 | | 3 | 3 | 3 | | |
| 14 | | 3 | 2 | 3 | | |
| 15 | | 2 | 3 | 3 | | |
| 16 | 2 | 3 | 3 | 3 | Complaints and protection (16-18): Good | |
| 17 | | | 3 | | | |
| 18 | 2 | 2 | 3 | 3 | | |
| 19 | 2 | 2 | 2 | 3 | Environment (19-26): Good | |
| 20 | 2 | 2 | | | | |
| 21 | | | 2 | 3 | | |
| 22 | | | | | | |
| 23 | | | | | | |
| 24 | 2 | 2 | 2 | 3 | | |
| 25 | | | | | | |
| 26 | 3 | 3 | 3 | 3 | | |
| 27 | | 3 | 3 | 3 | Staffing (27-30): Good | |
| 28 | | 3 | 3 | 3 | | |
| 29 | 2 | 3 | 3 | 3 | | |
| 30 | 2 | 2 | 3 | 3 | | |
| 31 | 2 | | 3 | 3 | Management and administration (31-38): Adequate | |
| 32 | | | | | | |
| 33 | 3 | 2 | 2 | 2 | | |
| 34 | | | | | | |
| 35 | 3 | | 3 | 3 | | |
| 36 | 2 | 2 | 3 | | | |
| 37 | | | | | | |
| 38 | 2 | 1 | 2 | 2 | | |

Scoring:

4 = Standard Exceeded (Commendable) 3 = Standard Met (No Shortfalls)

2 = Standard Almost Met (Minor Shortfalls) 1 = Standard Not Met (Major Shortfalls)

The NMS scores for CH 1 show that inspection has induced small quality improvements since May 2005, particularly in outcome areas where there has been a stepwise increase from scores of 2 to 3. The home had performed relatively poorly in the inspection previous to the one I observed especially against Standard 12. There were also a number of Standards (7, 9, 14, 33) where the service has maintained or dropped back to an adequate score without showing much improvement between inspections. In general the home has improved from an adequate to a good service and is only being let down by standards 2 and 38.

Limitations of system based on inspection against NMS

The NMS scores do not tell the whole story of inspection or the performance of the service. Simple analysis of the NMS only shows where an improvement has been achieved to the extent that a step improvement in scoring is warranted, from say 1 to 2, but fails to show if any incremental improvements within each scoring level have been made. These incremental improvements may not warrant a change in score but show progress towards the next level. To determine if any changes had been made incrementally during the case studies I used the follow-up data collection points at six weeks and nine months.

Questions concerning the value and usefulness of the NMS as indicators of quality have been a central theme of this thesis and will be addressed later in the chapter and in Chapter 7. Simple analysis of NMS scores has to be placed in the context of the value of these scores and whether they represent quality as viewed by residents or whether they represent a linear quantitative assessment that is convenient for the regulator but misses the subtleties of the care provided. This question relates to a question about whether the CSCI have got the inspection process right.

CHARACTERISTICS OF A KEY INSPECTION (KI)

This study was based on observation of the annual Key Inspection (KI) of four homes in England. At the time of my study every home in England received an annual KI; since the conclusion of data collection this has now changed so that the best performing services

(those rated as 'excellent') now get a minimum of one inspection every three years, but poor services still receive one each year.

The Department of Health developed a set of 38 standards which every service is checked against. The 18 most important are checked at every Key Inspection (KI) (Department of Health 2001c: 82). The other 20 do not have to be checked at every inspection but must be checked at regular intervals. These standards are not legally enforceable but rather operationalise the Care Home Regulations (2001), which provide legal minimum care requirements.

The KI is the primary evaluation of a service and determines what the regulator thinks about the quality of a particular service. If there are acute problems or overall poor performance in any one of the seven outcomes areas then this is enough to cause a poor overall rating for a service, which, at the time of this study, the CSCI noted internally only. There may be other random or thematic (for explanations of these two inspection processes please see Care Quality Commission 2009) inspections during the inspection cycle to follow up areas of poor performance, but the quality rating comes from the KI alone. It is important that the KI is done efficiently and correctly because from a provider's perspective it provides a quality rating for the service that lasts for at least a year. This rating has the potential to exert a large influence because it can affect whether local councils choose to purchase beds with the service, or whether individuals decide to live in a particular home. From the CSCI perspective the KI is at the core of the regulatory process and it is important it functions to improve quality in services judged adequate or poor and maintain quality in services providing a good or excellent quality of care.

The CSCI (2008b) states that all Key Inspections (KI) must include the following stages:

- **Stage 1:** Planning and mapping of evidence
- **Stage 2:** The involvement of people who use services
- **Stage 3:** Fieldwork activity (including a site visit)
- **Stage 4:** Consolidation of evidence
- **Stage 5:** Making judgements on outcomes
- **Stage 6:** Awarding a quality rating
- **Stage 7:** Reporting and closing down

Each inspection is given three days of resources, which conventionally equates to a day to plan the inspection, a day for the site visit and a day to collate the data and write the report (CSCI 2008b). Two inspectors expressed their reservations about always managing to collate data and write the report each in a single day, but the CSCI claim that advances in tools to aid the recording and writing process, which will be discussed in this chapter, should make this almost universally possible.

PLANNING THE INSPECTION

On the day prior to each inspection I had a meeting with the inspector to discuss their planning for the following day. The discussion covered their methods of preparation and my analysis highlights both similarities and differences in the approaches of each inspector.

Inspectors use various types of information to prepare for the inspection:

1. Previous reports
2. Complaints to CSCI (although latterly through the study these were dealt with in-house by services, without being reported to the CSCI, or referred to the council)
3. Questionnaires sent out prior to the inspection
4. Accident reports
5. Any information the CSCI might have from the local council (this is very dependent on the CSCI relationship with the council)

Together these individual sources of information allow the inspector to build a picture of the service prior to the site visit. They serve to show problem areas already apparent prior to inspection and also show where problems might be occurring and need to be checked. The use of these sources not only highlights problems but also builds an initial picture of the service and helps flag changes since the last inspection.

Previous Reports

At the planning stage each inspector went through at least the previous two inspection reports and in two cases (CH 1 and CH 3) through more. In case studies 1 and 3 the inspectors decided to go beyond the previous two reports because there were outstanding issues that stretched back beyond the previous two visits. In these cases the inspector wanted to be up-to-date with all previous documentation on the issues, as well as the timescale involved.

To the inspectors the use of previous reports had two main purposes, which reflected the two core principles of the CSCI: to ensure minimum standards and foster constant improvement (see 2006d). In terms of ensuring NMS are met previous reports were used as a preparation tool by inspectors. They showed the inspector what outstanding issues they needed to review during the site visit. Secondly, they helped to establish background context prior to the inspection. Inspection is a cumulative process and the inspectors were looking for constant improvement and development over and above correcting any poor performance, even in services rated 'Excellent'.

Use of questionnaires

In each of the case studies the inspectors used the questionnaires to highlight any praise, problems or grievances made by the stakeholders in response to an annual consultation. In addition to previous reports these provided the particular, case-by-case, areas of focus or concern for the inspector, offering an additional level of information to augment data collected during the site visit. If they were available inspectors particularly valued questionnaire data because it documented the direct views of service users or their families.

The value of these questionnaires to inspectors was dependent on the type of response service users gave. Each of the inspectors used the responses from the questionnaires to focus their inspection and direct them towards issues important to key stakeholders, and in particular the residents. Those submissions that carried clear opinions and useful responses formed a key tool of the inspection process as they facilitated focus on service user outcomes. As inspector of CH 3 claims:

‘Questionnaires are great if we get meaningful responses... we can use them to focus on the areas the residents see as important and can check all is good for them... its just unusual to get much of a response, and this home is particularly bad’ (Inspector CH 3)

However, there was also great frustration voiced by all inspectors that the questionnaires were not fit for purpose and this was reflected in the low response rates found across the cases⁴. The questionnaire was composed of a series of tick box questions followed by a short space at the bottom in which the respondent can write their own unstructured comment. As the inspector of CH 1 explained the questionnaire design was not conducive to detailed, critical responses, or appropriate for what was often a frail target group:

‘They’re far too short and the front is only a tick box, once you done that you have to be pretty bothered about something to write on the little line at the bottom... and you also have to remember that some old people aren’t able to do so’ (Inspector CH 1)

The same inspector also had reservations about the usefulness of the questionnaires in light of the seemingly prevalent fear amongst residents that their response might get fed back to the service, either formally or by accident:

‘You see they are often scared we’ll tell the manager and it will affect their care. They think they will be victimised if we say they are complaining’ (Inspector CH 1)

The questionnaires were used by all of the inspectors but were only of limited value because there had been little improvement in the document. There was frustration at perceived organisational neglect on behalf of the CSCI, especially considering the focus of inspection is supposed to be on service user outcomes. Each inspector thought that they should be redeveloped and tested in order to become more usable for the service user and thus more useful to the inspector.

Accident Reports

In a sign that the CSCI felt progress had been made in base-line quality of services, accident reports were only a minor feature during inspectors planning for a site visit. There had been a shift in the significance of accident reports for inspectors because protocol had shifted accountability onto the management of the services. Inspectors only got involved if internal processes did not deal with the complaint and the issues were left unresolved. The inspector of CH 1 helpfully described the shift in significance:

‘Accident reports really produce a line of accountability, the process of making homes report accidents means they have to deal with them properly and that’s good in the sense that they know they’ve got to act properly, but short of checking they’ve dealt appropriately with the accident and the necessary risk assessments are in place when we visit they don’t really inform the rest of our visit.... I guess it just means we don’t have to spend so long looking over the records during the visit’
(Inspector CH 1)

The CSCI stance on these reports represented a shift in the accountability from the regulator to the provider; with the CSCI checking the accountability process was in place rather than the details of complaints. As the inspector of CH 4 described:

‘Well if they’ve got a process to deal with complaints in place we don’t need to look at everyone ‘cos they should be following it up’ (Inspector CH 4)

Official view

In this section I have reported the ‘official view’ of information and tools in the sense that I report how the inspectors used and valued each aspect. It was obvious from discussions with other stakeholders that this information was used for different purposes, for example managers spoke of using reports as a guide to improve or persuade their superiors that they needed more resources. These issues are discussed in the later findings chapters.

Organising the inspection: The Inspection Record (IR)

The IR was introduced in early 2007 to provide a template document on which inspectors were expected to record inspection data. It was designed to support the inspector by simplifying the recording process during the inspection and making it easier to transfer data onto the final report. It also provides a permanent record on file for inspectors to use during the planning stages of subsequent inspections. The main purpose of introducing the IR was standardisation of the recording procedure to align judgments and eliminate inconsistencies.

Despite training and guidelines its introduction led to continuing diversity of inspectors' approaches. Each of the four inspectors used the IR differently. In fact three out of the four devised their own methods to transform the record into a usable document, with only one inspector (CH 4) using it in the format it was designed to be used.

One inspector refused to use the record at all and instead used his own system. As he explained:

‘I mean it just doesn’t work as it should at the moment, it’s more of a hindrance than a help. They say they’ve done consultation over it but, I don’t know. I mean hopefully it’ll be developed more... so no I don’t use it’ (Inspector CH 1)

The inspector of CH 2 used the record during the planning stage and typed his pre-planned questions within the relevant outcome section, but during the site visit he made notes on to a notepad instead of the record itself. Here the IR was used as a tool to guide and focus the inspection, but not as the integrated tool that the CSCI intended.

The inspector of CH 3 used the record to make her inspection notes, but reorganised it to fit a preferred layout, with the pages for recording inspection data matched to the NMS guidance.

The inspectors felt marginalised by the CSCI’s process of developing and introducing the record, they expressed frustration at the perceived lack of consultation over its development and consequently felt it did not function in a way relevant to their needs.

Despite the CSCI developing tools in conjunction with inspectors it got it wrong at the organisational level and this failure has had a negative impact, in terms of frustration and time consuming extra work to modify the record.

However, it has also produced an interesting consequence in that systems developed to increase standardisation actually made three of the four inspectors use their discretion to improve usability of the IR. Paradoxically the recent introduction of an IR has caused consequences antithetical to its aims by leading to a diversity of approaches by inspectors. Bell et al (2008) have also reported this phenomenon in the context of social workers use of the new Integrated Children's System (ICS).

Negotiating a time to start the site visit

The final decision of the planning process was to determine what time the inspection should begin. It transpired that the inspectors' choice of start time gave an interesting insight into their overall approach to inspection. Each inspector had slightly different reasons for the time they choose.

The inspector of CH 2 had a clear opinion of the start time. They wanted to arrive at breakfast time in order to observe that particular part of the day. Breakfast time is one of the busiest periods in a care service's day and the inspector saw it as an ideal time to see both the home during a busy period, when they reasoned any underlying problems would surface, and to catch them off-guard when all members of staff would be busy and not able to react to the inspectors' arrival. It was this surprise element that seemed particularly important to the inspector. They argued that there was only a short period after arrival when the staff and manager of the service are off-guard and therefore unprepared to be observed, and the inspector of CH 2 wanted to use this period to:

‘...get a chance to see the home in as real a situation as possible’ (Inspector CH 2)

In contrast the other inspectors decided they wanted to arrive after breakfast. I asked all three about this decision and the common answer was ‘because we don't want to disrupt the home at the busiest period’ (Inspector CH 4). They were less concerned with the need to ‘catch the home off guard:

‘I think we’ll find the problem anyway, its not like I’m going to see anything extra by going at breakfast’ (Inspector CH 4)

The phenomenon of conflicting inspection styles was also found to exist between local authority nursing home inspectorates during the mid-1980s in research by Day and Klein (1987) and between individual environmental inspectors by Hawkins (1984).

THE INSPECTORS’ APPROACH TO INSPECTION

The trend amongst the inspectors was flexibility towards designing inspections based on individual services. Rather than have a standard plan of action they would structure the day based on evidence synthesised during the planning stage. The inspector of CH 3 was keen to point out that she would attend the inspection with a plan of action, but this was not concrete especially if she felt the service would try to cover things up when they saw the inspector arrive:

‘I mean I make a plan the day before, like... and yeah its usually pretty similar in terms of what I do, but if things change then it’s flexible... you know, like if they’re all running round taking stoppers away from doors then I might do a tour of the premise first’ (Inspector CH 4)

Pragmatism: balancing organisational directives and professional judgement

There was a concerted view that where possible the inspectors would use every tool in their armoury to collect the best possible data on the service. The inspectors all acknowledged usefulness of a compliance-based approach (Braithwaite, et al. 2007) and unsurprisingly found it easy to improve quality if the service, and the manager in particular, was prepared to cooperate:

‘Well obviously it’s best if we can get the manager to understand why we’re making the requirements and things, then they tend to get it sorted’ (Inspector CH 4)

The CSCI began with a remit of toughening up the inspection procedure by raising minimum standards and my case studies suggest that this stance has resulted in inspection procedure developing under a deterrent-based ethos (Braithwaite, et al. 2007), in which inspectors issued threats if the service failed to improve rather than helping it to do so. Interviews with inspectors and care home managers suggest that where compliance-based approaches have had an impact in improving quality of services the inspectors have had to implement this at a local level using their discretion.

At its inception the CSCI took on a joint remit with two main strands: a policing or enforcement strand, where they are tasked with ensuring minimum levels of care by ‘stamping out bad practice’ (CSCI 2008a: 17); and a capacity building strand, through which they focus on ‘improving standards’ (CSCI 2008a: 17) across the board.

Inspection tended to focus on the ‘stamping out bad practice’ strand, a stance symbolised by the insistence that the inspector not give any direct advice or assistance to a particular service. However, managers and inspectors invariably saw the deterrent toolkit of CSCI as ineffective. The managers felt that a bad report was not in itself a necessary deterrent, because in the words of the manager of CH 1:

‘I mean as far as I’m aware none of our residents here looked at reports before moving in. We’ve certainly had no one asking why we’ve got a poor report at the moment’ (Manager CH 1, interview 2)

A second reason for the lack of effective deterrents is that enforcement procedure is incredibly laborious. The regulation manager of CH 2 explained that it can often take over 12 months to bring a legal enforcement order, and the process is very time consuming for the commission, as she explained:

‘It is a lot easier for us (*the regulator*) if we can persuade a service to make the changes rather than have to take action against it, and we don’t want to do that anyway, I mean it’s peoples’ livelihoods for a start’ (RM CH 2)

That is not to say that the regulator is not prepared to take action, and indeed issued 1205 requirement notices, 493 statutory notices, 11 urgent cancellations and 1 prosecution during 2007-08 (CSCI 2009). But this stance might reflect the fact that the CSCI does not have immediate enforcement powers; it cannot close a service without going through a long legal procedure (CSCI 2008).

The services were aware of this fact, even if they were not expert in the procedures of the CSCI, because for the services in my study all had carried outstanding requirements from previous reports and failed to receive any punitive action for doing so. When coupled with the fact that many private residents do not read reports the deterrent aspect of CSCI is relatively weak.

The Inspector's dilemma: giving advice

The inspectors in the case studies argued that advice was not about providing a consultancy service, but about devising the best way to induce improvements. The inspector of CH 4 summed up the position:

‘I just think that with some of them you need to look at other ways of making them change, and often it’s about persuading them it’s the right thing for them’
(Inspector CH 4)

All of the inspectors I studied had worked in regulation prior to the nationalisation of the social care inspectorate, and they all vented frustration at the CSCI’s lack of willingness to allow inspectors to advise services. There are strict guidelines against giving advice, but they would sometimes slightly moderate this deterrent-based stance:

‘We’re not allowed to give the homes any help really no, I mean I do sometimes say ‘look at this website’ or this might help... it can be frustrating at times yeah, but I guess that’s not our role’ (Inspector CH 1)

This opinion conflicted with the CSCI leadership. The Commission justify their stance through the registration procedure and other capacity building initiatives, such as working with the General Social Care Council (GSCC) to develop good practice frameworks and

training requirements. Both owners and managers must be registered with the commission and during this registration process they have to demonstrate that they are sufficiently qualified to do the job (see Department of Health 2000a). The CSCI argue that these measures ensure managers should have the technical and managerial competency to address any failings the Commission finds and they should not need any advice from inspectors. The RM interviewed in case study two admitted that the inspectors she managed had difficulties in accepting this position:

‘Inspectors have to get their head round the fact that we’re not there to manage the service, that’s for the home to do’ (RM CH 2)

Aside from the resource drain on inspectors’ time, the danger of offering advice was neatly summed up by the RM in case study 2:

‘I mean you can see why they don’t want inspectors offering advice, I mean at the extreme we could get blamed if they do something an inspector says and something goes wrong, or in the least it gets criticised next time... we could be making a rod for our own back’ (RM CH 2)

This dilemma was a key theme throughout the case studies and will be discussed with specific reference to the impact of inspection in the remaining data chapters.

THE SITE VISIT

Having examined the planning of inspections and the individual inspectors approaches, I now move onto discussion of the visits to the services.

Collecting the evidence

The evidence and data an inspector must collect is tightly governed by CSCI protocols and every part of the process must have an outcomes focus with judgements made based on Key Lines of Regulatory Assessment (KLORA) (CSCI 2007c). These guidelines give a description of the type of evidence each home is required to have in place in order to meet the conditions at each scoring level. However, the inspectors have the professional

freedom to organise the process of the day as they see fit, which means the inspectors organise their site visits differently. As I have already described they had different opinions about when to commence the visit, which sheds light onto their respective theoretical underpinnings and approaches to inspection, and this was also true of the schedule for the rest of the day.

The table below outlines a brief structure of each of the inspections I observed.

Table 14: Timetable of the day for each inspection

| | CH 1 | CH 2 | | | CH 3 | CH 4 |
|---------------|---|---|-----------------------------------|---|---|---|
| Step 1 | Arrival (Day 1) | Arrival | | | Arrival | Arrival |
| Step 2 | Interview with senior staff while waiting for manager in his office. It became apparent the manager not present and most of required paperwork is locked away. | Inspector 1 Observe breakfast and talk with residents | Inspector 2 Tour of premises | Inspector 3 Observe medication dispensing during breakfast | Brief chat with manager to explain the plan for the day | Brief chat with manager to explain the plan for the day |
| Step 3 | Interview with senior supervisor – mainly questions about whether things have been improved since last inspection (specifically related to requirements and recommendations from last report) | Interview with residents and staff who were serving breakfast | Speak to residents in their rooms | Tour of meds facilities and storage | Brief tour of downstairs plus and informal chat with groups of residents in the two lounges | Tour of premises (accompanied by manager) |
| Step 4 | Chat with co-owner (not manager) | Examination of paperwork | Interview with assistant manager | | Examination of paperwork | Examination of paperwork |
| Step 5 | Tour of premises | Interview with staff (x3) | | | Interview with staff (x2) | Talking through some of the paperwork with manager (for clarifications) |
| Step 6 | Interview with residents (x3) | Interview with relative (x1) | | | Tour of premises | Interview with residents (x2) |
| Step 7 | Interview with staff (x2) | Conference between 3 inspectors | | | Interview with residents | Interview with staff (x2) |

| | | | | | | |
|---------------|--|--------------------------------|--|--|--|------------------------------------|
| | | | | | (x3) | |
| Step 8 | Interview with relatives (x2) | Talk with manager and feedback | | | Talk with manager and feedback n.b. no relatives visited home during the inspection | Brief interview with relative (x1) |
| | | | | | | Talk with manager and feedback |
| | Day 2 | | | | | |
| Step 1 | Arrival | | | | | |
| Step 2 | Interview with manager and examination of paperwork, including examine the files of the particular residents spoken to during the previous visit | | | | | |
| Step 3 | Inspection feedback | | | | | |

Table 14 shows that each inspector covered all the component parts stipulated in the CSCI inspection framework; what differed was the order in which these areas were examined. This was determined by a mixture of personal preference, decisions based on evidence at the planning stage, and a reaction to the circumstances of inspection. This section examines the strands of inspection and analyses the inspectors' differing approaches to the inspection process.

Duration of Inspection

Although the duration of each inspection in this study varied quite considerably, from three hours to two days, there was a remarkable similarity between the actual hours devoted to each inspection. The CSCI state that 'the site visit will usually last one day, but may be more depending on the size and nature of the service and the issues arising' (CSCI 2008f: 1) and this seemed to be true of all of my case studies.

Table 15: Time taken by each inspector on the site visit

| Case study | Real-time duration | Man-hours |
|-------------------|--|---------------------------------------|
| 1 | Day 1: 9.30 – 12.30 Day 2: 9.30 – 14.00 | 3h + 4h 30 minutes = 7h 30 minutes |
| 2 | 08.30 – 11.15 | 2h 45 x 3 inspectors = 8 h 15 minutes |
| 3 | 09.30 – 17.15 | 7 h 45 minutes |
| 4 | 10.30 – 18.00 | 7 h 30 minutes |

In Case Study 2 the inspection was carried out by three different inspectors simultaneously: the primary inspector; a pharmacy inspector who was there to focus on standards for medication; and the Regulation Manager (RM). In this instance although the inspection only lasted for less than 3 hours, there was actually over eight hours of inspection time during that period, because each of the three inspectors worked simultaneously.

In Case Study 1 the inspection was conducted over two days, which on face value appears to be a much longer visit. However on this occasion the manager was not available on the day of the first inspection visit and a number of the documents the inspector needed to see were locked away. Although the inspection spanned two days there was little difference between the duration of this inspection and the other three because the inspector finished

earlier on the first day once they reached the stage where they needed to examine records that were not accessible without the manager and went back for another half-day two days later.

It is interesting that the inspections appeared to take a similar amount of time across the case studies and indicates that there is a reasonable consistency between both individual inspectors and the different CSCI regional offices. As this study only examined services performing 'adequately' or 'poorly' against the NMS it would be interesting to examine whether there is also an inter-level similarity in duration between the lower level services and the 'good' and 'excellent' homes, or whether less time is spent examining these services.

Structure of the day: what to do first paperwork or interviews?

After initial introductions had taken place the inspectors began the main stage of the inspections. As with the timing of the inspection the structure of the day appeared to be significant in terms of the inspectors approach. The two core parts of the day, in terms of both time and significance, were the examination of paperwork and interviews with stakeholders.

The order in which inspectors choose to inspect these areas offered further insight into each inspector's approach. Two inspectors choose to examine the paperwork first, before speaking to any staff or residents, reasoning that this would provide evidence of potential problems with care, which they could then ask the residents about. A third (of CH 1) inspector spoke to residents and took a tour of the building before looking at any paperwork. However, in this case the managers absence forced the inspector to conduct their inspection in this way. I asked the inspector what approach he took on a 'normal' inspection and he claimed he would:

'...tend to examine the paperwork first before speaking to residents and staff... cos it has the potential to flag up issues I might want to ask the residents about' (Inspector CH1).

The inspector of CH2 chose the opposite approach to the other three and opted to speak with residents before examining paperwork. His reasoning was entirely dichotomous to the other inspectors in that he wanted to see if conversations with residents flagged up any issues he should then follow up while examining the paperwork. When I asked him about this he reasoned that the records could not represent what service users thought about how they were being treated and so this needed to be questioned. He did not want to be influenced by paperwork fearing that this could influence the questions he asked:

‘I don’t want to be guided by clever documentation, I like to hear it from the horse’s mouth first, so to speak’ (Manager CH 2).

The inspection of paperwork

Table 16 shows that the majority of the inspectors’ visits were taken up by paperwork.

Table 16: Time spent on paperwork (rounded to nearest 5 minute interval)

| Case Study | Time in minutes spent on paperwork | Percentage of visit |
|-------------------|---|----------------------------|
| 1 | 190 mins paperwork out of total 450 mins with service | 42 % |
| 2 | Approx. 290 mins (Inspector = 85 mins, Pharmacist = 105 approx, RM = 100 mins) ⁵ out of a total of 495 mins with service | 59 % |
| 3 | 210 mins paperwork out of total 465 mins with service | 45 % |
| 4 | 195 mins paperwork out of a total of 450mins with service | 43 % |

N.B. time spent checking medication records is counted as paperwork

Although I did not make a note of the time spent on other aspects of the inspection no one other aspect came even close. The inspectors of CH 1, 3 and 4 all spent roughly the same time on paperwork, with the inspector of Ch 2 taking about 15 % more time. However, there were three different inspectors at the visit to CH 2 and there was a certain amount of overlapping between the inspector and the RM. The pharmacy inspector’s presence also skewed the result because much of his time was spent going through medication records in great detail, after initially watching medication being dispensed. Such an intense examination would not usually happen during a routine inspection.

Styles of examining paperwork

Although the inspectors spent a similar amount of time looking through paperwork the manner in which inspectors collected data was one of the areas that varied quite distinctly between two approaches.

The first approach, exhibited by inspectors of CH 3 and 4 was to check through the paperwork evidence thoroughly and methodically, picking up on any problems as they went through and relating these to the NMS retrospectively. This was a holistic approach, with the inspectors trying to understand the whole picture of the home rather than just checking for evidence of individual standards. It requires an in-depth working knowledge of the standards and guidelines because the inspector must be able to determine where things are missing without specifically focusing on a particular standard.

The inspectors of CH 1 and 2 approached paperwork differently using the NMS and KLORA guidelines to sift through the paperwork for evidence of each particular standard, letting the standards guide the data collection. This appeared to be a more efficient but less holistic approach, which could potentially miss wider overarching failings and meant the inspectors gained a less holistic picture of the service.

Questioning the paperwork

It was necessary for all inspectors to talk through the paperwork with the manager at some point for both practical and substantive reasons. The manager had to signpost inspectors to the appropriate documentation and there were always points of clarification that inspectors wanted to question. In this context the inspectors structured their time looking at paperwork in two different ways: two (CH 1 and CH 4) choose to sit in the office with the respective managers and go through the paperwork with them available to answer questions. In these instances the manager sat and worked and stopped to answer points of clarification or discuss any issues the inspector brought to their attention. The other two inspectors (CH 2 and CH 3) preferred to have the managers direct them to all of the paperwork, look over it first and then question the manager on any anomalies or missing pieces of information retrospectively. The two inspectors who choose to examine the paperwork away from the manager sacrificed expediency for independence; they wanted to

avoid interference or intervention from the manager, in the form of them making excuses, that might have influenced their appraisal.

Case tracking

Inspecting for Batter Lives (IBL) was introduced in 2005 and mapped the changes the CSCI wanted to make to improve inspection over a three year period. As part of the changes introduced in IBL all inspectors are expected to case track during every inspection (CSCI 2005a). The aim of this was to follow the 'cases' of two or three residents through all aspects of the inspection process, to generate an overall picture of the service they receive and determined whether their desired personal outcomes have been first identified and then met by the service.

The inspectors all valued case-tracking and saw it as a key facet of the inspection process that facilitated triangulation of evidence and determined whether systems described in the paperwork were being implemented in practice. As the inspector of CH 4 pointed out:

'To really focus on one or two individuals and follow-up the paperwork with confirmation for the residents, on a range of things from activities to number of staff makes me much happier about deciding on the rating for a home than just taking the paperwork for granted or asking residents questions without first knowing what the home is claiming to be doing' (Inspector CH 4)

The benefits of case-tracking are in both the level of detail that can be examined and the way in which the findings can be applied to the rest of the service population. It is unacceptable for the service to be failing one resident so any areas of service that are deficient in one person's care can be extrapolated to the rest of the service population. It allows the inspector to build a picture of the whole system of care, rather than just individual processes or outcome areas.

Consulting service users

Interview schedule

All of the inspectors had some form of interview schedule which they used to structure their conversation with the residents. These schedules varied quite considerably as it was one of the few areas where the CSCI had not prescribed guidelines. In light of findings that suggest inspection is becoming increasingly prescribed it first appeared strange that there were no guidelines or standard question templates, but after observing the planning and site visit a lack of prescription made sense. First, the inspectors needed to be able to tailor their questions to evidence from previous inspections and any new information that may have come to light, this made every site visit unique. Secondly, the inspectors needed flexibility to ask questions specific to residents' lives and care. In this context any form of protocol or standardised questionnaire would be counterproductive.

The lack of standardisation inevitably resulted in different approaches from each inspector. The inspectors of services 2, 3 and 4 were very organised and all had some form of pre-prepared written schedule based around the seven outcomes areas with questions to address each section. The inspector of CH 2 developed these during the planning stage based on analysis of previous reports and other available information, which meant he targeted questions based on shortcomings from previous inspections. The other two inspectors developed a basic set of general questions around the seven outcome areas as well as specific question related to previous failings. They also added additional notes / questions during their examination of the paperwork, based on missing data or areas that they decided required corroboration.

The inspector of CH 1 spoke to residents without any formal preparation of questions, but instead guided himself through the seven outcome areas using his copy of the NMS and his inspection record. When I asked whether this was his usual method of interviewing residents he claimed:

‘... I don't usually like a schedule no, but I would usually have some notes from my examination of the paperwork, it's just unfortunately this time I had to speak to the residents first so I wasn't that prepared to be honest. Usually I'd have a bit of time after looking at the paperwork, over lunch or in the office, where I could make

sure I knew what I wanted to ask and also who I specifically wanted to talk to based on having looked at their care plans... this time I had to do it the other way round, which I've done before but it's certainly not my usual way of inspecting' (Inspector CH 1)

The fact that the inspector of CH1 had no schedule and was conducting the inspection in an unusual (although not unique) order meant that his style of questioning and conversation with the residents was disorganised. Despite this disorganisation the inspector had a lengthy conversation with one resident and briefer conversations with another two, in which he managed to touch on all seven outcome areas, from opinions on staffing levels to the most important aspect for the resident: their health and personal care and daily life and social activities.

The value of interviews with residents

Policy emphasis on personalisation of service and achieving successful outcomes for service users means that a key aspect of the inspection process is speaking with residents. Even if all of the paperwork appears to be in place and up-to-date, if residents express serious concerns with their care then the inspector must ensure these are explored and resolved. This means the time spent talking to residents was seen as the most valuable part of the inspection by all inspectors:

'The purpose of our job is the residents. I want to see that they are happy not only in general but also that they feel the care they are receiving is up to standard, and you can't determine that through the paperwork, I've known homes to look great on paper, but the minute you speak to residents it becomes a different story' (Inspector CH 1)

Paradoxically, as we have seen, this was not the area that inspectors are generally able to spend most of their time on, which was a cause of great frustration. As the inspector of CH 3 explained:

‘You see we should be spending ninety percent of our time out in the home talking with residents and observing practice, but we just don’t have the time’ (Inspector CH 3)

Interviews with residents focused on outcomes, which essentially mean the impact the service has on the people using it. They check whether the processes put in place by the service and documented by the paperwork were actually having intended outcomes for residents, rather than just subjecting them to generic outputs. In addition these interviews also determined whether the care delivered by the home had been devised in consultation with the service user. The NMS set out desired outcomes for each standard and were devised with intensive user consultation (see Department of Health 2000a) to ensure the home will be delivering a personalised service if staff are doing their job properly.

Interviews with residents typically lasted between 10 and 20 minutes, with two exceptions across the studies were residents were very keen to talk. Across all of the cases it was often difficult for the inspectors to keep the residents engaged with questions concerning inspection, and there was a tendency for residents to deviate from the questions being asked. In these cases the inspectors were acutely aware of the time constraints they were under and tried to steer the conversation back towards inspection.

Residents’ reluctance to give full disclosure

Older people move into residential care because they can no longer look after themselves without intensive support. Residents are often vulnerable and rely on the care home to meet their needs. This reliance meant residents were hesitant about giving a full and frank assessment of the service they receive. Many were scared that any criticisms they divulged to the inspector would be reported to the manager of the service and they would be ignored or marginalised because of their disclosure. Data from the case studies reflected this, the majority of resident I spoke to across the sites claimed they would be reluctant to be completely honest with the inspector because as one resident described:

‘I’m not going to say anything just now because I don’t want to make trouble for myself... no... maybe in a year or so... haha’ (Resident CH 4, interview 1).

In order to marginalise this phenomenon as much as possible when talking to residents the inspectors had to be sensitive to these concerns, while at the same time getting the residents to give an honest appraisal of their care. All of the inspectors were sensitive to the potential worries of the residents and were careful to make assurances that anything they said they did so in confidence, unless it was a specific issue that the resident wanted the inspector to raise on their behalf (which happened with one resident during case study 3).

Consulting staff

Inspectors' preparation for conversations with staff working at the case study sites was very similar to the preparation for resident interviews: the three inspectors who prepared a question schedule for resident interviews did the same for their conversations with staff and the inspector who had no interview schedule for the residents had no schedule for his conversations with staff. Questions to staff were obviously different to those asked to residents, they tended to be more technical and focused on the systems and processes that are required to be in place to ensure favourable outcomes (as defined by NMS) for each resident.

Some staff were similarly hesitant to divulge to an inspector, one in CH 4 admitted she did not tell the inspector her real appraisal of the service performance for fear of repercussions. However, most with whom I spoke insisted they were open and honest with the inspector.

Consulting relatives

Talking to relatives can be problematic during an unannounced inspection because there is no guarantee any will be present during the visit. Inspections typically last a full day so it is unusual for there to be no relatives present at some point, but it is not uncommon. This was proven during the inspection of CH 3, when no relatives visited at any point during the day. The inspectors at the other three sites all spoke to relatives, and all managed to speak to a relative of at least one resident with whom they also spoke. Where possible the inspectors were keen to speak to a relative of at least one of the residents they were case-tracking because the views of this relative provided an additional piece of evidence with which to build the case and make the best possible judgement of outcomes for that particular individual, and by extrapolation the service as a whole.

Concluding the visit: Feedback

At the end of the inspection the inspectors are required by CSCI guidelines to give initial feedback to the care homes. As they have not had time to synthesise and analyse all of the data, the feedback was informal and the inspectors were sure to emphasise that none of their judgements were final until the report had been published.

The inspectors were all relatively brief with their feedback, emphasising that they could not give a true appraisal and judgement until they had time to consider all of the evidence. All were reluctant to give scores for the individual outcomes areas but did give a provisional overall judgement. However, it transpired after the publication of the report that their initial feedback of findings was remarkably similar to the outcomes of the report. This suggests the majority of judgements are made *in stiu*, in the mode of what Schön (1983) terms reflecting *in practice* rather than based on analysis and *on practice* reflection after the event.

All four inspectors explained their findings by going through the seven outcomes areas and giving both areas of strengths and areas that needed to be improved. The inspector of CH 4 felt it was important to give positive feedback where possible, especially because of the service's previously poor rating:

‘I think with these types of services it's important to stress what has been improved, if it has, and I think this service has made some good improvements...’

Giving advice on how to improve

Despite appeals from managers the inspectors were unable to give advice about how to make specific improvements. The CSCI had a clear policy on this, outlined in the IBL document that defines the role of the CSCI as a regulator and not a consultancy or troubleshooting service. When asked about why they no longer maintained this supportive practice all four inspectors cited the organisational constraint of CSCI policy:

‘It was a lot more of a supportive role before... we had an announced and unannounced, where as now its an overall review, we’re not their to advise and support’ (Inspector CH 4)

Two (CH 2 and 3) specifically mentioned the fact that the manager is supposed to be qualified and competent to conduct all aspects of the job and it is not up to the inspector to do their job for them.

However, despite their acceptance of the CSCI position three of the inspectors were frustrated by it and thought their services would improve faster if they had been allowed to give more constructive advice. All of the inspectors had worked for previous local council run inspection organisations and were used to giving advice at the point of feeding back to the service, especially to the small, less sophisticated providers:

‘I remember back in the local inspection days I’d be happy to help, especially to homes like this who have no other support... I’d take phone calls to give a hand... but we can’t do it now’ (Inspector CH 3)

Catalytic feedback

Although they were not prepared to offer specific advice two of the inspectors did offer what Braithwaite et al (2007) call ‘catalytic feedback’ at the end of the inspection. This specific type of feedback works by encouraging a positive response to criticisms, and inspectors tried to do this rather than give specific advice. The feedback worked by trying to encourage the manager to build on existing strengths within the service and by working incrementally the larger problems could be overcome. For example the inspector of CH 3 declined to give specific advice to the manager about improvements required to the staff induction training, but she did comment on the ongoing improvements that had been made so far and stressed that these seemed to have occurred because the manager had brought in an external consultant from another service to help her for a day. The inspector commented that the manager should use this consultant again and that they were heading in the right direction. The inspector of CH 4 also gave similar feedback, encouraging the manager to use his / her own organisational strengths to develop better communication and teamwork across her staff.

AFTER THE VISIT

The Report

After the inspection the inspectors collated the evidence and wrote the reports. A draft report is sent to the home approximately four weeks after the inspection with an invitation for the manager (and owner if applicable) to comment on the findings. The CSCI will only amend factual changes, not disputes over any findings. Comments and disputes will be kept on record by the CSCI but they are not published as part of the report. The report is then published eight to ten weeks after the inspection.

All reports follow a set format, written onto a template and they have to follow guidelines on the use of plain English. The report is broken down into seven sections based on the seven outcome areas, with a brief summary of the report findings at the front. A summary of 'what the home does well' is placed at the beginning of the report and any requirements and recommendations are printed at the back of the report after the individual scores for each of the thirty-eight NMS that were inspected. The judgements have to be based on the KLORA guidelines (CSCI 2007c) and the report must contain evidence to support the judgements. The guidelines also stipulate how to structure each section, from layout, to the number of lines that should be written for each section, and what type of evidence should be used.

The reports for each of the four case studies show this uniform structure and all contained similar types of evidence to support judgements. The typical evidence used to support judgements for each outcome area are shown in Appendix 6.

All of the reports were of similar length ranging from 26 to 29 pages, with the majority of the extra length being attributable to a longer list of requirements tabulated at the end of the document.

In line with CSCI best practice guidance three of the inspectors used quotes from stakeholders in every section of the report to evidence whether or not outcomes were being achieved. According to the inspector of CH 3 the CSCI had only recently sent a

memorandum to regional offices to encourage a greater use of direct quotes in the writing of reports. This directive had obviously not filtered through to the inspector of CH 1 who failed to use quotes in any of the seven sections, but did use two within the summary section on 'what the home does well'.

There is a clear reason for the uniformity of reports. This has roots in the desire for the individual resident, or prospective resident, to be able to take responsibility for the decisions they make. The ability of the public to do this is dependent on the government producing consistent and accessible information. The CSCI want reports to be comparable to enable prospective residents to examine a number of reports and make fair and accurate comparisons about the quality of each service.

After each individual outcome section has been discussed in the body of the report the score for each of the 38 NMS are presented in a table form, under the heading 'Scoring of outcomes'. This table gives the score for each of the NMS that were inspected. Not every standard is examined at every KI, so only those standards that were inspected are scored.

Requirements and Recommendations

Following the 'scoring of outcomes' a table of requirements and a table of recommendations are listed at the end of the report. The first table lists 'Requirements', which are actions that must be taken to ensure the service meets the requirements of the Care Standards Act (CSA) 2000. If the requirement is statutory the enforceable regulations from the CSA 2000 are listed next to the NMS to show the legal justification for the stipulation. There is usually a timescale attached to the requirement that gives a timescale for the service to resolve the issue. Failure to adhere to this timescale can result in enforcement action being taken.

However, in the four case studies I conducted all services failed to meet timescales for at least one previous requirement and no enforcement action had been taken. Indeed CH 1 had failed to act on agreed timescales for five requirements from the previous inspection and received no subsequent enforcement action after this had been discovered during the case study inspection. This inaction reflects the difficulty the CSCI have in bringing

enforcement action against services. It is a cumbersome, long process which will be discussed further in Chapter 7.

The second table lists 'Recommendations' that relate to NMS and are seen as good practice for the Registered Provider (owner of the service) to consider carrying out. They are not enforceable against the regulations of the CSA 2000 and as such can be ignored. The managers seemed to neglect the significance of this section of the report as none discussed it in the context of using these to develop their provision of service. They were viewed as 'ideals', changes that could be made if the service had unlimited resources but which were often ignored in the face of requirements.

The recommendations given at the end of the report build upon the catalytic feedback given during the verbal feedback provided at the end of the site visit. They provide a list of areas that can be developed or improved and which if acted upon at this stage will improve the performance of the service. They usually discuss minor areas of the service which if developed will have significant cumulative value, both in terms of improving the individual area and providing incremental improvement which when combined will have a positive effect on the service as a whole. This section of the report provides a type of advice and gives the service a chance to improve areas before they become problematic, or simply to build on existing strengths. In keeping with the non-consultancy policy of the CSCI the section does not provide advice about *how* to achieve improvements, but usually they suggest actions that are straightforward and often, when achieved, combine in their constituent parts to develop the more complex practice pathways. There was a paradox between managers wanting advice from inspectors but generally ignoring the recommendations, when it is these pieces of advice that can provide a catalyst to larger improvements.

CONCLUSION

The inspections all followed a reasonably similar trajectory guided by the NMS and system guidelines (e.g. KLORA). In many ways inspection appears to be dominated by standardisation, with changes perceived by inspectors to be eroding their professional judgement. This standardisation spanned the focus of inspection and the technical judgements inspectors have to make, but has less influence over the process.

However, despite increasing of standardisation being implemented by organisational decision-makers inspectors' use of discretion was evident, often in quite innovative ways that resulted from rebellion against the process of standardisation. For example, in the unique ways in which inspectors reorganised the IR to make it usable and in the two distinct ways the inspectors conducted their inspection of paperwork:

1. Holistic - examining the paperwork thoroughly and methodically, picking out problems as they went through and relating them to the NMS retrospectively
2. Targeted – using NMS and KLORA to find evidence of each particular standard

Although there was scope for discretion the inspectors expressed frustration at the level of prescription by the CSCI, which they felt was slowly eroding their professional role and replacing the need for reflective skills with the de-skilled ability to simply routinely collect data and match it against a checklist. This de-skilling mirrors Braverman's critique of scientific management, elements of the concept can be seen in the evolution of the inspection process (Braverman 1975). However, there were areas where inspectors were able to exert their professional autonomy in the ways they structured the day and crucially in their interviews with stakeholders. There was also scope for some inspector discretion that fell within the guidelines of the CSCI if the inspector was prepared to be a little inventive and to bend the rules slightly, as in the case of the inspector of CH 3 who allowed the service to fax a fire certificate 2 days after the inspection. These findings echo the work of (Evans and Harris 2004) who demonstrate that discretion is not a phenomenon that is either present or absent it is used in specific instances.

The parallel working of both strengths-based and deterrence-based philosophies is a particularly interesting feature of the inspection regime. This philosophical tightrope is traversed both at the top-level of the CSCI, in the development of organisational frameworks and protocols, and at a street-level by inspectors on the ground. The deterrence philosophy is the dominant feature of the CSCI and strengthening this aspect of inspection was a clear founding principle when it began in 2004. While the focus of regulation since the Care Standards Act 2000 appears to be on deterrence-based approaches, these were also complimented with certain strengths-based aspects to foster compliance. For example, the emphasis on 'what the home does well' at the beginning of the report and the use of recommendations at the end of the report to suggest areas where improvements can be

made and current strengths can be built upon. However, the strengths-based aspect of regulation was described as minor in relation to the deterrence-based aspects by both inspectors and care home managers, who certainly felt the deterrence aspects of the system far outweigh the compliance.

Two of the care home managers (of CH 1 and 3) complained specifically about the lack of positives in the reports, and it appeared during my observation of inspection that most the strengths-based initiatives came predominantly from informal actions by inspectors, such as the use of 'catalytic feedback'. The balance between these two seemingly opposing philosophies is explored further in Chapter 8.

There was clear evidence of both a perceived and a real shift from inspecting to auditing, with the CSCI orientating more focus towards auditing quality assurance systems as opposed to directly checking the quality during the inspection. This was evident from the inspectors claims about increased emphasis on paperwork and the amount of time they spent looking at paperwork in comparison to other aspects of inspection, particularly talking directly with residents. Further evidence such as the CSCI only auditing the services complaints system rather than assessing the actual complaints and the adoption of self-reporting in the form of the Annual Quality Assurance Assessment (AQAA) (introduced in 2007) has further emphasised this shift towards auditing. The inspectors' views on this bureaucratic shift was negative and reflected their concerns about the remit of their jobs, which they felt were both being eroded by efficiency savings and bureaucracy.

In this chapter I have taken the inspectors accounts as a straightforward realist account of inspection and used them to supplement my observations. In subsequent chapters I examine the views of other stakeholders in more detail and explore contrasting interpretations of the inspection process as well as the consequences for the service function and residents well-being.

CHAPTER 5: IMPACT ON SERVICES

INTRODUCTION

After exploring the process of inspection in the previous chapter I now move on to looking at the impact inspection had on service provision. Impact can be measured in terms of direct impact on the service during the process of inspection itself, through the outcomes of the inspectors' reports, and exploring whether the process induces change in service provision. I am also interested in the consequences of inspection and determining how and why the manager and staff within the service reacted to inspection.

To examine these issues analysis in this chapter is split into two parts. The first, examines of the impact of the site visit, how it affected the service on the day and how the prospect of unannounced inspection visits impact on the service in terms of obtrusiveness and disruption.

The second part looks at longitudinal impact to explore whether CSCI actually induces changes and whether these changes improve the performance of the service and quality of care. In Chapter 4 I briefly analysed the three previous National Minimum Standards (NMS) scores for each service to look at the progress the services had historically made against the standards. That data provides context to the case studies and shows that where progress was made it has previously been limited.

IMPACT OF INSPECTION SITE VISIT ON MANAGERS AND STAFF

In this section I explore how the services reacted to inspection in terms of service change. None of the staff I interviewed had read the report and those who know about the findings only knew what they had been told by their manager. In the case of CH 2 and 4 the managers had discussed the report with staff in a staff meeting by the third data collection point. This was only a brief overview of the requirements and a value judgement by the manager. In CH 1 and 3 the managers had not discussed the report with staff.

All of the managers and staff reacted pleasantly to the inspectors and accepted that external inspection was a necessity for services that look after vulnerable adults. Impact was manifest in two ways: disruption to the service and emotional stress.

Disruption to the service

The presence of an inspector during the site visit obviously had an impact on staff and all staff I spoke with talked unanimously about ‘being on guard’ and ‘taking that extra bit of care’ that day. Many were keen to point out that this caution was not because they felt they were doing their job poorly at other times but simply a result of the added tension and pressure created by the situation. My observations during the inspections suggested that the staff tried to get on with their jobs while the inspector was observing them or touring the home. The tendency was for staff to avoid the inspector if possible. In only one instance did a member of staff approach an inspector to have a conversation. A staff member in CH 2 explained why she wanted to avoid the inspector:

‘I’m not going to try and speak to him, I don’t want to say the wrong thing or bring attention onto me... if he asks me anything I’ll try to answer it to my ability, ‘cos I know the job...’ (Staff 2 CH 3, interview 1)

The impact on staff performance was demonstrated by the Assistant Manager of CH 2 who made a mistake during the dispensing of medication that led the service to receive an immediate requirement from the inspector. I missed the incident as I was observing the lead inspector rather than the pharmacy inspector, but she left medication open and unattended and blamed the lapse on the presence of the inspector:

‘I give out the meds all the time. It was a mistake I admit that, but I really think it was because he was there, it does throw you off you know’ (Staff 2 CH 2, interview 2)

Emotional stress

Every member of staff I interviewed at each case study site admitted to being nervous about working while the inspector was observing and many were wary of speaking openly

because they feared the potential consequences. Those with little or no experience of previous inspections were more cautious when answering their questions during the day. Staff in CH 3 had experienced a large number of random inspections over the previous two years because the home was failing to comply with regulations. This meant that many of the staff were familiar with both the process of inspection and the inspectors themselves. This familiarity led to less apprehension and more open dialogue between the inspector and staff. As a member of staff describes the relationship:

‘Yeah we feel like we know (the inspector) now and I know I might as well just be honest and answer what she asks me, we’ve got nothing to hide’ (Staff member CH3)

The stress of inspection was always in the mind of the manager. This pressure was accepted as ‘being part of the job’ and managers certainly did not show resentment to the process, in fact they were favourable to a system that provided a regular check and hopefully affirm of the good job they do. The manager of CH 4 even spoke of looking forward to an inspection because she would hopefully get a ‘pat on the back’ from her employees. Similarly staff admitted that the fear of an unannounced visit at anytime is a motivator for good practice. In the words of one member of staff from CH 3:

‘It keeps me on my toes’ (Staff 1 CH 3, interview 3).

Frustration at inspection

When I returned to the service at the second data collection point I asked the managers about their initial reaction to the report and inspection. They tended to describe the judgements in the report as ‘fair’ in the sense that they were evidenced and related to the standards:

‘Yeah I mean the report is what I expected, it’s fair, I haven’t got my NVQ yet and I’m not able to do all the supervisions they want so yeah it’s fair’ (Manager CH 1, interview 2)

Despite accepting the report he was hostile to the regulations and the process of inspection. He described regulation as dictatorial and felt it was interfering in *his* business, which he should be free to run according to market principles. He felt the system was favourable to large homes who could afford to do more because of economies of scale:

‘I find the dictating part of the inspection offensive. It’s my business. I should be able to say “look, it might not meet all of your standards but residents have a choice and they can have a nice family service in (*name of village*) that gives good basic care in a lovely setting or go to a big 50 bed home and get a care plan like *the inspector*) thinks we should have”... If they gave us advice we would be more than happy to take it onboard... They don’t help us improve the service no, I mean they won’t give us any advice, it’s like we’ve got the manual and he ensures we’re doing that... they keep us on our toes... they never say ‘Have you tried doing this?’, or ‘This would help’ (Manager CH 1, interview 2)

The manager saw inspection as adversarial and felt that it would achieve its goal of inducing improvement if it was more constructive in its criticism. Another criticism was that the balance of the report unfairly highlighted the negative conclusions:

‘I don’t like the fact there was a very short passage of what the home does well and then twelve pages of negatives, there should be some balance... with the format it would be much better if they gave the positives and the negatives at the same time, to say well here’s what they do well, but here’s what needs to be better’ (Manager CH 1, interview 2)

Inspection outcomes

Despite the report presenting scores against each standard inspected and an overall score for each of the seven outcomes areas within the report, the services focused their attention predominantly on the requirements listed in the back of the report. These requirements were treated as ‘action points’. There was no critical analysis of scores or analysis of particular low scoring areas with a view to improvement. The requirements were interpreted to be a definitive, exhaustive illustration of what needed to be changed in the

service, rather than urgent errors that required attention because they contravened the Care Home Regulations 2001. As the Stand-in Manager of CH 2 explained:

‘Well we’ve looked at addressing the requirements, that’s what we have to do’
(Stand-in Manager CH 2, interview 2)

The previous chapter touched upon the modernisation agenda of the CSCI and demonstrates a shift towards audit principles. As the CSCI continues along this direction of travel it relies more heavily on managers to independently evaluate and act upon the inspection findings. CH 2 and 4 did quickly submit a plan of improvement to the CSCI but this only set out how they would address the requirements. CH 1 and 3 failed to submit this document until very late in the study period more than 6 months after the inspection.

IMPACT: CHANGE OVER TIME

The study was designed with a longitudinal aspect in order to explore consequences of inspection over a nine-month period. As requirements represented the focus of services reaction it is necessary to understand how each service reacted to these.

To analyse this I first looked at the number of requirements issued to each service and analysed how the services acted upon them. The second data collection point was approximately one week after the report was issued and only 4 – 6 weeks after the inspection. Services had not usually had time to make any changes by that point, except where they were very minor or simple to rectify and had been fed back to the service during the informal feedback process.

The data were analysed through a conceptual lens influenced by micro-level organisational theory (Garside 1998). Analysis takes account of the influence of both structure and agency in the services reactions to requirements and examines how these two factors interact. In considering this interaction I was also influenced by Giddens’ concept of ‘duality of structure’ (Giddens 1986: 25) within the care home setting. Using Giddens’ conceptualisation of Structuration (Giddens 1986) structure interacts with agency in determining a manager’s leadership. Human agency and social structure are related to one

another, and it is the repetition of the acts of individual agents that reproduces the structure.

Appendix 7 shows a table of the requirements issued to each of the four care homes and tracks the progress services made at addressing failings flagged in the reports. Table 17 below summarises the larger table, showing the number of requirements made in each of the four reports and whether they were acted upon by the service.

Table 17: Number of requirements made in report which were ‘actioned’ by the service

| Report | Number of requirements issued in report by theme | Number of requirements ‘actioned’ ¹ by end of study | Number of requirements not ‘actioned’ by end of study | Number of requirements partially ‘actioned’ by end of study |
|-------------|--|--|---|---|
| CH 1 | 8 | 4 | 3 | 1 |
| CH 2 | 6 | 5 | 1 | 0 |
| CH 3 | 5 | 0 | 5 | 0 |
| CH 4 | 5 | 4 | 0 | 1 |

¹ The term ‘actioned’ signifies the fact that I could only determine if the home had made changes and was satisfied it had rectified the problem. I was not in a position to determine if they had met the requirements as judged by the inspector.

Table 17 shows that by the end of the study period of the 24 requirements issued over the four inspections eleven had not been ‘actioned’ by the services. CH 3 did not take action on any of the requirements issued in the report. CH 1 had only taken action on four of eight requirements and made partial progress on a fifth. Comparatively CH 2 and CH 4 had made much better progress with CH 4 acting upon all five of the requirements and CH 2 only failing to act on one.

The rest of the chapter explores the reasons behind the services either acting upon or not acting upon requirements.

Themes of requirements

The requirements focused on six thematic areas, with a number of sub-themes (which are labelled in the tables in Appendix 7). The six thematic, and the respective sub areas were:

Table 18: Requirements ‘actioned’ grouped into themes

| Themes of requirements | Number of requirements across case studies | Number of requirements ‘actioned’ |
|------------------------------------|--|-----------------------------------|
| 1. Care planning | 4 | 0 |
| a. Personalisation | 2 | 0 |
| b. Activities and stimulation | 2 | 0 |
| 2. Management | 4 | 0 |
| a. Qualifications | 2 | 0 |
| b. Supervision of staff | 2 | 0 |
| 3. Staff | 5 | 4 |
| a. Training | 3 | 2 |
| b. Recruitment | 1 | 1 |
| c. Numbers on duty | 1 | 1 |
| 4. Medication | 4 | 2 |
| a. Policies and procedure | 3 | 1 |
| b. Safe storage | 1 | 1 |
| 5. Documentation | 5 | 5 |
| a. Safety certificates / insurance | 3 | 3 |
| b. Working documents | 2 | 2 |
| 6. Environment | 2 | 0 |
| a. Safety | 1 | 0 |
| b. Refurbishment | 1 | 0 |

Of the requirements, those pertaining to documentation were most likely to be acted upon. This was mainly as a result of CH 4 which had four requirements that stipulated the need for the service to hold necessary documentation on site. The documents were held at the head office of the parent company and were quickly retrieved by the manager after the inspection.

Care planning was criticised in CH 1 and 3 and neither home had managed to make successful progress on this by the end of the case study period. The managers of CH 1 and 3 had both failed to achieve their NVQ qualification in management and in the case of CH 2 this meant the manager had still not passed the CSCI fit persons test and was not the registered manager of the service (the manager of CH 3 was already registered because she had been in position prior to the Care Standards Act 2000). Neither manager had achieved their qualification by the end of the case studies.

Changes not related to inspection

Aside from the inevitable change in residents due to death there were relatively few changes not related to inspection during the case study period.

The biggest non-inspection related change was that, following national legislation, the smoking ban had come into effect and this was having a considerable impact on services. As the manager of CH 4 explains it had induced considerable stress:

‘The smoking ban has been a nightmare, that’s the big thing at the moment. I’ve got staff having to go off the premises, and they don’t like that. I’ve got residents complaining they’re not allowed to smoke in their rooms, and they’re being shunted into a small room with no one else...’ (Manager CH 4, interview 3)

Changes made as a result of the smoking ban were often the first issue on residents and staff lips when I asked about changes and this had more impact on their consciousness than any of the changes that resulted from inspection.

All four homes had had changes in staff personnel and this reflects the transient nature of the care home workforce, which is discussed later in this chapter.

The compliant and the non-complaint service: a simple typology

The data in table 18 above and data from my observations and interviews suggest that there were two types of approach to dealing with the outcomes of inspection. CH 2 and 4 were broadly compliant with the requirements in the report by the end of the case studies, with both services ‘actioning’ all but one of the requirements they were issued with. In contrast CH 1 and 3 were less compliant, especially CH 3 which had not made any progress towards addressing any of the requirements issued in the report. CH 1 had addressed four of the eight requirements but had been slow in addressing the other four. The attitude and approach of the manager in CH 1, who was overtly defiant of the CSCI at the beginning of the research, was an additional factor in the characterising of the service as non-compliant:

‘We’re a small, intimate home... we have nice garden... there’s no smell and they’re safe, what more do they want. I don’t think it’s right. Take supervision, I’m

not doing that, some staff have been here for years, why do they need supervision?’
(Manager CH 1, interview 2)

The simple dichotomy between the two types of service does not tell the whole story. Appendix 7 and Table 18 show that in general the requirements that were acted upon were those that were relatively straightforward to complete. They also generally involved the least resources in terms of time and money to fulfil. For example the four requirements that CH 1 had fulfilled were:

1. Updating staff documentation – by getting references from all staff that were not in place previously.
2. Providing training in food hygiene for kitchen staff – all staff who worked in the kitchen had been on a day training course.
3. Staff training to dispense medication – the manager had limited the staff who give out medication to the supervisors and only one of the three needed training and she had been on the relevant course.
4. The home had added an extra member of staff to the afternoon shift and part of their responsibility was to arrange daily activities.

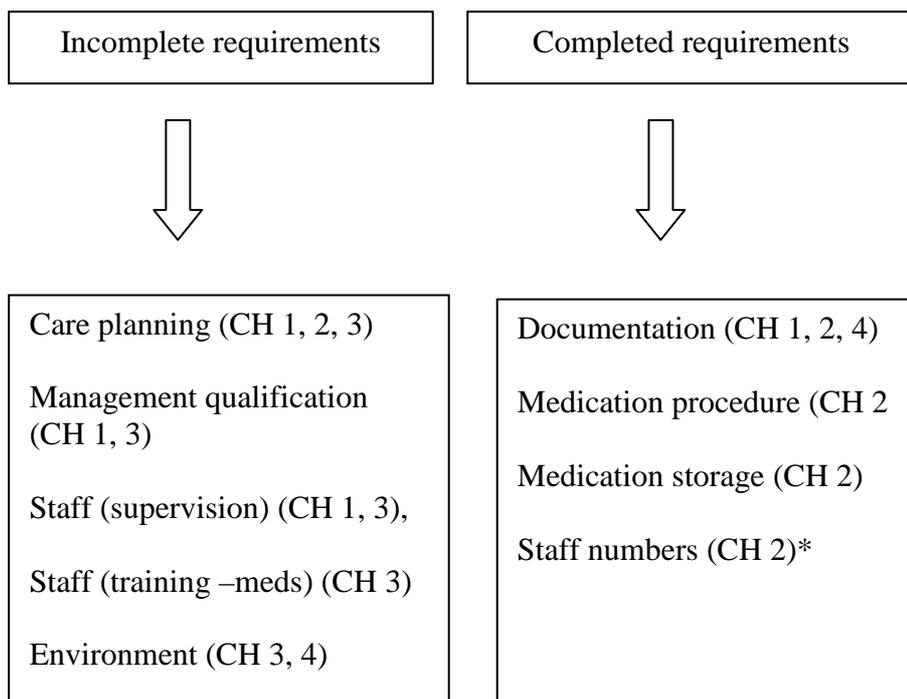
In contrast the requirements that had not been acted upon involved a reworking of current organisational methods within the service, which the manager seemed unable to carry out. The requirements around improved care planning and staff supervision had not been carried out. Neither had the manager gained his NVQ qualification nor applied to be registered with the CSCI (which he could not do until he was qualified).

CH 4 acted on all but one of the requirements it was issued, yet the four it acted upon pertained to documents that were held off site and were immediately retrieved from head office. The fifth requirement to stop wedging doors open was being rectified through the fitting of magnetic doorstops, but this renovation was only partly complete. Similarly the only requirement CH 2 had not rectified focused on a review of care planning.

Therefore a more sensitive analysis of the data suggests that dividing the services as compliant and non-complaint based on the completion rate against requirements is simplistic. Instead there seems to be a thematic division based on the type of change required in the report. Those changes that required large-scale organisational change of

operational processes and staff behaviour, such as care planning or staff supervision were left uncompleted. Changes that were relatively straightforward and could be executed without the need for organisational change were rectified. Figure 1 shows this thematic division:

Figure 1 Thematic map of incomplete and completed requirements



** Manager claimed he constantly reviewed staffing and had decided current levels were appropriate. He therefore made no change*

The analysis is slightly skewed by CH 3 which failed to act on any of the requirements, including the relatively straightforward task of refurbishment. However, Figure 1 shows a clear differentiation between care planning, management qualification, and staff development, which all require some form of organisational change to complete and the more straightforward tasks of completing documentation, refining medication procedure (which is highly prescribed), and adding extra staff. Apart from the care planning requirement in CH 2, which was not acted upon, all of CH 2 and 4’s requirements did not require organisational change and therefore were completed relatively quickly. The outstanding requirement for CH 4 was in the process of being completed; it was being delayed by the firm being employed to fit the new doorstops.

Common responses to inspection

This next section explores the reasons behind the services actions in response to the requirements issued. The focus is on the areas of change that were incomplete and explores the reasons for the lack of change.

A lack of urgency

Initially it appeared there was lack of urgency displayed by all but CH 4 in reacting to the inspection requirements. Previous timescales had been missed by all four services and in the case of CH 1 a timescale on a requirement for formal staff supervision went back to June 2005. The problem was systemic across the studies and related to a set of interacting issues that include a lack of perceived threat and the time and resources to implement complex change.

The manager of CH 2 explained why there was often a lack of urgency in an admission that the consequences of inaction were perceived as minimal:

‘I mean it doesn’t really change anything here. Life still goes on... we still have new residents wanting to move in, I had a call yesterday, but we’re full at the moment... I’ve never once had a resident or their family ask for a copy of a report and no one has questioned me about a report ever’ (Manager CH 2, interview 1)

The timescales are supposed to be legally enforceable through the Care Home Regulations 2001 but evidence from previous reports shows that timescales are rarely enforced. The RM of CH 2 explained this position:

‘... we only take enforcement action if we really have to because it takes so long’
(RM CH 2)

The lack of urgency was also attributed to the time and resources it takes to implement organisational changes, especially where changes were large and involved considerable bureaucracy:

‘It takes a long time to develop new care plans you know, they’ve got to be designed and of course CSCI don’t help you with that, then we’ve got to train the

staff in them, and that's not easy especially when it means more paperwork for them' (Manager CH 1, interview 3)

When change involves a shift in working practices in terms of the behaviour and attitudes of staff, the changes can take a long time. Time has been shown to be a barrier to organisational change (Lee 2008).

Management acting as a barrier

As the leader of the service the manager is the single most important factor in improving the service's quality rating: they have the capacity to foster staff development and dismiss those who are not performing appropriately; they can introduce new policies and practices to improve the quality of service; and crucially in relation to inspection, oversee the implementation of any requirements and recommendations made by the inspector.

Capacity for service change therefore primarily lies in the manager's desire *and* ability to achieve change and these factors in turn relate to their understanding and acceptance of the need for change. The inspectors were very clear in their opinion that the manager was the key factor in creating change. As the inspector of CH 3 explained:

'Oh the manager is crucial they are the single most important factor in whether a home fails the inspection, er, they drive the service and are responsible for its success' (Inspector CH 3)

All four managers were critical of some of the changes the CSCI require, which when coupled with the perception that defying the CSCI had little consequence meant there was a reluctance to act on requirements. The criticism was based on a perception that changes were for the benefit of the CSCI not residents, as the manager of CH 4 claimed:

'I mean you do have to question whether everything they ask from us is necessary and not just for the inspectors, I know they've got a job to do but it seems too much, you know' (Manager CH 4, interview 3)

The managers of CH 1, 3 and 4 were frank and open about their reluctance to make some of the changes, feeling they were sometimes too demanding:

‘I’m not going to ask busy district nurses and doctors to give me their opinion on the service here, they’ve got more important things to do than spend five minutes filling in a card’ (Manager CH 1, interview 2)

‘Sometimes I think things can be, how can I put it? Unnecessary, like I mean I know I didn’t have the certificates on site but they’re at head office and they could’ve just faxed them to (*the inspector*) that afternoon if (*the inspector*) had wanted’ (Manager CH 4, interview 2)

Capacity for change

I purposefully selected my case studies from the pool of services that had previously been rated either poor or adequate by the CSCI, as I reasoned that these would be where I would see the most impact. However, focusing on these homes also vividly demonstrated an interesting tension that exists between the ongoing tightening of assessment and control systems by the regulator and the capacity of local leadership for change (Newman, et al. 2008). This tension appears to be even more acute because homes, at the ‘poor’ or ‘adequate’ end of the quality ratings spectrum, are by definition struggling with adhering to the NMS and accompanying regulations.

In CH 1 the inspector thought the manager’s perceived stubbornness and unwillingness to admit his failings coupled with a lack of knowledge about some aspects of care provision, were holding the service back:

‘It’s his autocratic style of management you see, it’s not a style that gets the best out of people, and you could see that by the way his staff spoke about him’ (Inspector CH 1)

The inspector of CH 3 had similar complaints about the manager’s lack of knowledge:

‘I think she’s a bit stuck in her ways and not willing to learn about the new way of doing things, I must admit it must hard after doing it one way for 20 years’
(Inspector CH 3)

They identified this as the key barrier to improvement and in his opinion the key motivator for improvement was education. Both managers’ knowledge of care needed to improve and the inspectors felt this would come with the appropriate qualifications. They felt that the required training would help persuade the manager of current prevailing values of choice and control in care.

Structural barriers

When explaining the lack of progress over time managers argued there were ingrained structural barriers that prevented changes. For example the Manager of CH 3 argued that she did not have enough time to make the changes herself:

‘...to be honest I know the supervision and training isn’t enough for (*the inspector*) but I just don’t have the time, you know and I honestly don’t think the staff could do it, or benefit from it that much’ (Manager CH 3, interview 2)

Managers were increasingly finding it difficult to allocate already scarce resources towards achieving the modernisation the CSCI required. As the manager of CH 2 explained:

‘... I mean they say you’ve got to do activities but there’s no money to do them... It’s frustrating that they demand so much yet give no help with how we’re supposed to stretch our resources’ (Manager CH 2, interview 1)

For the owner-manager of CH 1 the resource issue was resolved through an outdated conception of good quality care provision, justified through resource limitations:

‘Do you know the cost of property here Matthew? We provide these grounds and a well maintained service and it doesn’t cost a fortune, I know other homes that charge two hundred pounds more a week than us, but we don’t because we want to serve the community... for that they get good basic care and my staff chat and

interact, if you like, with the residents, but we just don't have the capacity to put on lots of activities, and I tell you when we have done in the past not many here have wanted to take part to be honest... families should take more responsibility, why can't they come in the evenings or at least during weekends and take them out, walk them round the garden? I mean some do, there are one or two who are great, but others just don't bother' (Manager CH 1, interview 2)

He focused on the environment and argued the home provided good basic care, in a well-maintained home, in a pleasant village setting. He admitted they focused less on activities and stimulation. He justified this by claiming residents got what they paid for and argued that their families should take responsibility for providing additional contact and stimulation. The manager of CH 3 also voiced this sentiment and felt that her residents were content with the service she offered and the increased demands around personalisation and care planning were unnecessary, certainly in the context of a lack of resources.

Although she too complained about a lack of resources the manager of CH 4 put a positive spin on the role of inspection. Even though CSCI requirements required extra resources she could also use the report as a negotiating tool to attract more resources from the parent company:

'well it's good in way because I can say look I need more money for activities or whatever, and its down here (*in the report*) in black and white so they can't argue'
(Manager CH 4, interview 2)

Using Giddens' (1986) theory of Structuration as a framework for analysis there is a social structure within services - traditions, moral codes, and established ways of doing things. These can be changed when people start to ignore them, replace them, or reproduce them differently. Managers in these case studies were functioning within an organisational culture premised on ageist concepts of decay and dependency (Wilken 1990). This was affecting the behaviours of managers, staff and, as I will discuss in Chapter 6, residents. This dominant structure is demonstrated in the routinisation I observed in all four services.

Each service showed varying degrees of routinisation. For example all four had routine times for getting residents up and dressed, bringing morning and afternoon tea, lunch and dinner. There is a practical need for routinisation within institutional settings; however, the routinisation in all four homes was excessive, particularly in the context of increasing focus on personalisation. CH 1 had the most rigid routine:

‘The support we get here isn’t good, we’re just expected to get on with giving the care, keeping them entertained and doing the paperwork.. I mean we barely get time to get them up, give them breakfast and medication before its time for toileting, and then lunch, then toileting again, you know, we never stop... activities pah, we hardly get time’ (Staff 2 CH 2, interview 1)

The routine was not enforced, the resident who refused was not compelled to go to the toilet, but it was ingrained in the running of the service and therefore *de facto* enforced.

This type of practice, where residents are treated as part of a routine, rather than as individuals had supposedly been eliminated as a result of the new modes of care developed since the Care Standards Act 2000. However, pressures of time created by a shortage of staff and the burden of inspection meant staff had developed a routine to ease the burden on them, rather than provide optimum care for residents.

Staff resistant to change: the influence of prevailing culture

Across the case studies staff were unhappy about the changes that had already been implemented since the Care Home regulations 2001. Progress in the case study services was slow there had been limited progress against the NMS. Staff referred directly to the impact of CSCI:

‘I’m sick of it at the moment to be honest Matthew, it’s getting to the stage where its not worth it for me... this job used to be fun, I’d chat to the relatives have a laugh, now since CSCI have come along there’s too many hoops to jump through’ (Staff 1, CH 4, interview 2)

As with managers staff were constrained by their experience of, and buy-in to, an outdated culture of service, and were finding it difficult to shift their behaviour as prevailing policy

thinking had changed. Their resistance was partly the result of objection to an increased workload, which they felt was unfair especially without any change to their remuneration:

‘... these changes have given us a lot extra to do now, I often have to stay behind after a shift to finish me care plans, it’s the only chance I have to get them done... on top of the work I do for me NVQ on me days off’ (Staff 1 CH 3, interview 2)

As well as the extra personal workload staff were also concerned that the extra amount of paperwork negatively impacted on their caring role. To many of the staff I interviewed this seemed to be antithetical to the aims of social care:

‘I can’t understand it, how they think that all of this extra care plans and things are helping when they actually mean we have less time to spend with the clients’ (Staff 2 CH 3, interview 3)

Caring was conceptualised specifically as direct support and assistance for residents. In this context the care planning and record keeping were viewed as a hindrance to caring, rather than a process through which care is improved through accountability and personalisation. Other studies suggest time claims like this are endemic across the social services setting (Bell, et al. 2008). Observations from my field log do show that staff did spend a considerable amount of time on paperwork, especially at the end of their shift, but I had no point of reference to compare these claims against so can only take their claims on face value as evidence.

From the sample of staff I interviewed across the studies the willingness to change and embrace new techniques was related to each staff members own experience and perceived career path. Staff who had been in the job for a long period of time or who were reaching the end of their working life were less happy to embrace changes, such as detailed care planning, which required extra training and work. Others who wanted to remain in the profession were more willing to adapt to change.

Services focus on outputs rather than outcomes

All four homes saw success in terms of service outputs rather than outcomes for residents. Outputs are service products and differ from outcomes, which refer to the impact the service has on the welfare of service users. A quote from the Line Manager of CH 2 neatly sums up this output focus:

‘For example not one person has had a bed sore they didn’t come in with and things like that I think are more important than one person’s view, which they often use to make a judgement’ (Line Manager CH 2, interview 2)

The commonality of focus on outputs without the justification for these in terms of outcomes for residents was important in understanding the underlying reasons for services performing poorly against the NMS. Focusing on outputs allows service staff and managers to affirm their own role and the current function of the home, rather than question the service they were providing in terms of outcomes for residents and therefore have to make changes in response to these. For example none of the four services had residents’ meetings to consult over service provision. Managers were often frustrated at the lack of attendance at some of the activities they put on. However, my interviews with residents found that lack of enthusiasm was often because they were the wrong activities:

MN: ‘so you don’t do any of the activities?’

Oh no, I don’t like bingo’

MN: ‘Is there anything you would like?’

‘Well we used to play indoor bowls at me old place, I loved that’

MN: ‘But they don’t play that here?’

‘No’

MN: ‘And have they ever asked you what you might like to play?’

'No I don't think so'

(Resident 2 CH 4, interview 2)

Activities tended to be the obvious care home activities, like sing-a-longs or bingo, but residents wanted more varied things, such as the above example of indoor bowls.

To claim that manager and staff did not consider outcomes for residents is erroneous, more specifically they produced outputs based on their own assumptions of outcomes, which stemmed from their cultural perspective and resulted in a service which was often tailored to organisational needs and behaviour rather than the residents.

For the managers of the three privately run services there is an intersection of structures based on a profit driven mode of production and a social justice driven mode of production; the managers had to align these two conflicting influences. In the cases of CH 1 and 3 this pressure created a focus on limited outputs rather than holistic outcomes, because they could ally their notions of social justice with a narrow set of outputs. If they were forced to consider a wider plethora of outcomes it was apparent that the profit driven mode of production would be compromised because the two would be incompatible. They were essentially claiming their services only offer a resource limited level of care, which was appropriate to the cost of the service.

Factors that induced change

Despite complaints from all four service managers about the demands of inspection all but CH 3 had made progress against the requirements by the end of the study period. In the case of CH 2 and 4 only one requirement had not been acted upon. I have discussed the influence of the types of requirements services had to address and the technical ability and capacity of the service personnel to achieve change. This section now explores the reasons services began to comply with the inspection outcomes and discusses how services initially resistant to change were persuaded to begin to make improvements against the NMS.

Accepting the principle of CSCI

Although she thought some elements of inspection were unnecessary the manager of CH 4 was sanguine about inspection and happy to comply with the rules even if she did not agree with every standard and process for gathering evidence:

‘Er, I think we need the Commission and it’s a good thing, so you just have to get on with it... I like the feedback at the end, that helps... So you just have to knuckle down and get on with it’ (Manager CH 4, interview 2)

The manager of CH 2 was less sanguine but equally as pragmatic:

‘Well it happens and I can’t change it so we’ve just got to get on with it, listen to what they say and try to get it right for next time’ (Manager CH 2, interview 2)

Punitive sanctions finally getting through

The manager of CH 1 had steadfastly refused to accept the value of change during the first two data collection points. A couple of weeks before my third data collection point the service had received a random inspection, which is shorter than the Key Inspection (KI) and used to follow-up requirements to ensure they have been implemented (I was not made aware of the inspection so did not attend). Because there had been little progress over a long period of time there was a real threat of legal action from the CSCI. After a number of years of resisting change and ignoring the CSCI’s threats the manager seemed to realise that a critical mass of pressure had built up from the CSCI. He talked about the need to improve because the CSCI would begin legal proceedings if he failed to make progress with the key outstanding issues by the next KI:

‘I’ve had a kick up the arse to be honest. After a couple of conversations with (*the inspector*) I realise that I might lose the business if I don’t get things sorted. He’s talking about legal proceedings and I don’t want to lose my business... I guess before now I’ve thought I could get away with having a home that’s not got a great CSCI rating because, well, residents were still coming in. But now it’s more serious now they could close me down potentially and I don’t want that’ (Manager CH 1, interview 3)

The fact that it seems to have taken the manager over three years to perceive that sanctions from the CSCI were real and could have an impact, beyond the publications of bad reports, shows that the threat of sanctions has not been backed by action from the CCSI. The manager acknowledged that CH 1 had reached the stage where only the threat of draconian measures were having an impact. It had taken the CSCI three years to reach this point where the inspector felt he had exhausted all of his patience to the point where only very real threats of punitive sanctions would work in this case:

‘To be honest there’s been no real improvement over the last couple of years and I’m beginning to wonder what I can do now, I do wonder if I need to bring another inspector in to give a fresh look and fresh ideas’ (Inspector CH 1)

By the end of the data collection period the manager had enrolled on his NVQ and made progress with care plans. Although he would not admit it explicitly he gave the impression that the task of reviewing and revising the care plans was daunting, both in terms of the scale of the task and the knowledge required to develop the new plans. By the third interview he had managed to delegate the tasks and a new supervisor had been employed whom the manager felt was capable of developing the care plans. He also informed me that he was in the process of hiring a consultant to come in and do ‘a few trouble shooting sessions with us’ (Manager CH 1, interview 3), admitting he had been struggling with the management of the service. Rather than improve his own skills and knowledge base he chose to delegate responsibility to a new member of staff and a consultant, but he was beginning to accept the CSCI’s model of quality care, even if seemingly rather reluctantly through threat of sanctions.

In respect to his attitude there was evidence of some improvement by the third data collection point. Relatives and staff all claimed there had been an improvement in his communication and willingness to listen, and they thought this was beginning to translate into an improvement in service:

‘He’s better now he’ll at least listen to what we have to say and he does do things when I ask him, like when they lost mum’s jumper in the wash and he made sure it

was found, whereas before he would've just dismissed that request' (Relative 1 CH 1, interview 3)

'...well at least there is better attitude from (*manager*) now he'll listen to my suggestions a bit more and treats us with a bit more respect, whereas before we were just ignored' (Staff 1 CH 1, interview 3)

It had taken the inspector and CSCI three years to make the threat of legal action real. This demonstrates the hesitancy inspectors have to use this method and supports the comments of the RM of CH 3 about the difficulty in pursuing legal action.

UNDERSTANDING WHY IMPROVEMENT WAS LIMITED

Burden of regulatory regime

Regulation places a huge burden on services in terms of ongoing adherence to the standards on a daily basis and the impact of the vast amount of paperwork. In terms an ongoing adherence to standards managers felt the burden of regulation was too high, they felt there was a large imbalance between the *output* or benefits of adhering to regulatory standards and the *input* in terms of time and resources required to achieve them. They questioned whether some of the standards and inspection activity were simply there to justify the CSCI's own institutional position, rather than improve services:

'...I've actually had residents complain about the changes we've made in response to the report, and I want to see what (*the inspector*) says when I tell him this next time, I mean I thought inspection was for the residents, so if they don't like the changes what's the point in them Matthew?' (Manager CH 1, interview 3)

The manager of CH 2 thought the same thing:

'I think they sometimes focus on stuff that wasn't important to the lives of residents and won't make a difference to them at all' (Manager CH 2, interview 1)

Inspecting for Better Lives (IBL) (2005) shows the CSCI's intention to lower the burden of inspection. The document claims the CSCI's '(a)im (*is*) to reduce the administrative burden of inspections, particularly by reducing the amount of information we ask for.' (CSCI 2005a: 1). However, at the beginning of my fieldwork in 2007 the managers did not feel as though the burden had been reduced. In fact with the introduction of the Annual Quality Assurance Assessment (AQAA), a complex self-assessment document, they felt like the burden was being increased. As the manager of CH 4 explained:

'This new AQAA is a pain, we don't even have the internet here, so I'm not sure how I can do it online, its going to be even more work... and we're not even getting less inspection' (Manager CH 4, interview 1)

In reducing the burden on itself, by shifting towards a more cost effective risk-based regulatory regime, the CSCI had increased the burden on the service it inspects.

There was also criticism that homes were being forced to focus on paperwork and meeting the NMS at the expense of caring for the service users:

'I mean I really think we're getting to the stage now where I'm questioning whether we're actually running this home for the service users or the inspectors' (Manager CH 3, interview 3)

Similar criticisms have been made of performance management regimes in public service organisations (see Walker 1998) and other regulators, notably Ofsted, who have been criticised in the past for their focus on quantifiable targets, which were used as an automatic indicator of quality despite other forms of evidence suggesting that meeting these targets was not always improving education (see for example Cullingford 1999a).

The impact of technology

The impact of technology on inspection cannot be underestimated, especially in relation to the increase in rationality that comes with the information society (Lash 2002). Woolgar (2002) argues that Information and Communication Technology (ICT) configure the user by setting rules as to how users can act. Parton (2008) argues that in relation to social work

this has had an impact on forms of knowledge in the form of a shift from narrative to a database way of thinking; social work has moved from the ‘social’ to the ‘informational’. These arguments are clearly borne out in the case of inspection and the impact of technology has had a considerable effect on the construction of the current regime. Technology has facilitated the ‘modernisation’ of the inspectorate under the principles of new managerialism by focusing on a linear collection of informational indicators. This technology driven process is evolving contrary to the CSCI’s stated aims of focusing on user experience and this tension will be explored further in Chapter 7.

Shifting the goal posts

There was a common perception that the CSCI was constantly raising the bar and requiring more evidence to meet standards. Managers also felt that there was a lack of adequate notice or information about the changes. This led to frustration for managers and left them feeling unable to keep up with constant changes, which resulted in an almost defeatist attitude:

‘It is sometimes difficult to keep up with all of the changes they bring in... er... I mean... you feel as though you’re just getting to grips with one set of rules and they change things again and that means new paperwork’ (Manager CH 1, interview 1)

The changes were not made to the Care Home Regulations (2001) or NMS, they were made by the CSCI in the pursuit of ‘a constant improvement of standards’ (CSCI 2006d: 1). They do this by tightening the guidelines under which the inspector judges each standard. They are able to exert this influence through the ‘administrator’s prerogative’ (Croley 1998). In the pursuit of progress the homes struggling to adhere to the current level of standards were being further left behind. The CSCI created a problem for itself because as the goal-posts shifted services already performing poorly were falling further behind acceptable levels of care, in the case of CH 3 the manager felt might eventually close them down:

‘I mean I’m not sure how long we can keep this up, it feels as though the inspectors are trying to push us out of the market, they don’t seem to realise the problems of small independent homes’ (Manager CH 3, interview 3)

In response to accusations about a lack of assistance with constantly changing regulations the inspector of CH 3 explained to the manager that the information was in the public domain. The inspector suggested the CSCI website held all relevant information, and the Skills for Care website had advice on how to meet the changes. However, despite maintaining the official position to the managers, during my interviews all of the inspectors expressed some sympathy about the pace of change and the accessibility of information required to make changes:

‘I mean I do understand the problems the manager has in achieving all these, especially for a small independent home like this one where money is clearly a big issue’ (Inspector CH 1)

‘There has been a huge change in inspection and the pace has been horrendous and I personally think there should be more time for managers to assimilate that change’ (Inspector CH 3)

The regulatory burden: pushing smaller providers from the market?

The two managers of the small, independent homes were particularly aggrieved at the introduction of yet more administrative burden. As both Hood et al (1999b) and Power (1999) found as the scope of regulation expands so does the compliance costs for regulatees. The frustration at an increasing burden of regulation and the associated costs was coupled with a restriction from local councils on how much they would pay a home for each resident it funded. Managers have no control over this and have to abide by prices derived by the council based on a Fair Price for Care valuation calculated based on the Unit Cost of Health and Social Care produced annually by the Personal Social Services Research Unit (Curtis 2007). Managers can only then raise prices by the amount the council calculates each year. There was a concern that through a combination of quasi-market forces and regulatory burden the government and public sector were trying to push independent providers out of the care home market:

‘Everyone is entitled to the same care despite economic background, but the councils and government don’t see it like that... if we don’t get enough money coming in how can we be expected to provide the same level of care as a home that is completely private and charges £200 a week more than us?... especially when they’re (*the CSCI*) not prepared to help’ (Manager CH 1, interview 2)

The managers of both CH 1 and 3 were worried that they might be forced out of business by the continual raising of standards alongside increasingly restricted resources paid. The restriction of charges for council funded residents also restricted the charges they could make to private funders, whom they could not justify charging considerably more as they and their relatives would not accept subsidising the council funded residents.

CONCLUSION

Inspection caused disruption to the services and emotional stress to the staff and managers. In the main this was accepted as part of the inevitable process of inspection but all four managers complained that it took up a lot of their time during the visit.

The outcomes of inspection were reduced by managers to the requirements issued at the end of the report and the managers saw these as a task list. They thought requirements negated the need for further critical analysis of the report in order to target improvements based on strengthening the NMS that they failed to meet. This meant in order to look at the consequences of impact I had to structure analysis around the requirements in the inspection report.

Thirteen of the twenty-four requirements were acted upon by the services. Analysis of the requirements suggests they fell into six thematic areas:

1. Care planning
2. Medication
3. Staff
4. Documentation
5. Management
6. Environment

The requirements around documentation, environment and medication were more likely to be acted upon than those around care planning, management and staffing. This was because the latter themes all involved some kind of organisational change within the service. In this respect, although CH 3 acted on none of its requirements and CH 1 on only 50 %, a typology of the non-compliant versus complaint home was inappropriate. Rather the lack of change was the result of a complex interaction between agency and structure.

The managers and staff all exhibited some resistance to change, which was dependent on their knowledge and capacity for change. The lack of change can be seen in terms of Giddens' theory of Structuration where structure and agency interact in a model of service provision (Giddens 1986). In all four services the model of provision was influenced, to some extent, by an outdated conception of care resulting from a culture of ageism. This was most prominent in CH 1 and 3 and least in CH 2 and 4. The organisational culture was self-perpetuating and enhanced in the privately run homes (CH 1, 3 and 4) by an incompatible interaction between a profit driven and social justice driven modes of production. This culture of ageism was both reaffirmed and justified by a focus on outputs without adequate consultation with residents regarding outcomes.

The burden of the regulatory regime and a constant tightening of the criteria to meet the standards has created frustration for service that were already struggling to comply with standards. This has served to increase resistance to complying with the NMS.

CHAPTER 6: IMPACT ON RESIDENTS

INTRODUCTION

A central aim of this study was to examine residents' views of quality residential care provision: what they value, what they deem to be unsatisfactory, what changes they would like to see. This chapter uses data from interviews with residents and their relatives to discuss these questions and in doing so analyse the impact of inspection on those whom the services are aimed. This part of the study aimed to:

- describe the way residents and their relatives view the principle of inspection and the function of the CSCI;
- describe the extent to which inspection improves the quality of service as experienced by residents;
- determine whether inspection focuses on outcomes important to residents.

IMMEDIATE IMPACT OF SITE VISIT

Residents impassive to inspection

Residents were generally impassive towards the inspector and on the whole only residents who spoke with the inspector were aware of what they were doing. Staff in two of the homes (CH 2 and 4) reported one or two residents asking them 'why we were there', often commenting on the fact that we were wearing suits so must be 'important'. In contrast according to the staff in CH 1 not one resident with whom the inspector did not speak asked why we were there. This lack of awareness of inspection was confirmed during interviews after the inspection. When I asked residents if they knew there was an inspection the previous day only those who spoke with the inspector were aware it had taken place. In CH 3 the inspector's presence did arouse more interest and quite a few residents stopped the inspector to ask what they were doing. This seemed to be due to the fact that the inspector in this case study spoke to a number of residents while they were sitting in the communal area with other residents, the other inspectors tended to either visit residents in their rooms or take them to a empty room or quieter place.

No knowledge of CSCI

The limited direct impact on residents is further demonstrated by the fact that none of the residents I interviewed across the four case studies knew what the CSCI was or what it did. The residents who had been interviewed by the inspector on the day of the visit heard the name from the inspector and knew about the inspection from the limited amount the inspector told them during their interview:

‘I know she came round yesterday to chat to me about the home, like and whether they were treating me proper’ (Resident 2 CH 3, interview 2)

Those who had spoken to the inspector knew that inspection was conducted and that it had a protective function, to ensure they were not being mistreated, but were not aware of the organisation that conducted the inspection or the remit to which it inspects.

Obfuscated by complexity

Residents were clear that the principle of inspection was a good thing:

‘It gets everything out in the open, makes sure the staff here are doing what they supposed to be doing, which they are as far as I’m concerned’ (Resident 1 CH 2, interview 1)

‘Yeah I mean someone should check the home is treating us properly, you know, that there’s no problems’ (Resident 1 CH 4)

However, when I asked them directly about their views on good quality inspection residents found it difficult to give a general view on the facets of good inspection, instead acknowledging the complexity of the process and the need for expert knowledge. They established that inspection *per se* was a good thing but the complexity of the process was seen as a barrier to any real or meaningful engagement, as a resident from CH 3 claimed:

‘I don’t know about things like how they (*inspectors*) should do their job, I mean all I can do is say whether I’m happy I don’t know what they do’ (Resident 1 CH 3, interview 2)

Residents seemed afraid to expand on their views of good quality inspection for fear that their understanding might be questioned and their normative position contended:

‘Oh I don’t know how they should do it best, that’s for the government to decide, they know how to do it. All I know is it’s a good thing if it stops the home stepping out of line... you know in terms of abuses and things’ (Resident 2 CH 4, interview 1)

In this context they were not motivated to engage *collaboratively* with inspectors and involve themselves in the complexities of the process, nor did they believe they had the appropriate expert knowledge to do so. In light of the complexity of the process residents felt they would rather leave it to the inspectors, whom they saw as professionals with expert knowledge. However, they did acknowledge that their experiences were important and that the inspector should *consult* their knowledge to find out about service performance:

‘Oh yes they should ask us about the care here, they do all this for us so they should definitely ask us what we think’ (Resident 2 CH 1, interview 2)

It appeared as though a lack of empowerment was the key reason for residents’ apathy towards the process of inspection. There was certainly no evidence that notions of service user control or partnership in their care were acknowledged as favourable concepts.

No engagement with inspection outcomes

A key tool of inspection is to provide information on outcomes of inspection to people that use the service. The data from these case studies show that information was not reaching residents in these particular services. There seemed to be three interrelated reasons for this. First, the CSCI were not actively disseminating information to residents directly. Second, there was no compulsion or motivation for the services to actively disseminate the report to

residents. Thirdly, residents were not engaged with either the purpose or outcomes of inspection so were did not actively request the report.

All of the services held a copy of the report, but in three cases this was kept in the manager's office and in the case of CH 4 pinned to a notice board in the entrance to the service. None of the services had any form of residents' meeting to discuss the report with their service users and the outcomes were not actively disseminated. None of the reports painted a picture of an excellent service, which may have had some impact on the lack of publicity by the managers of the homes. When I asked them about disseminating outcomes to residents the managers excused their role in this by portraying resident apathy, as the manager of CH 4's response demonstrates:

'I don't think they'd be bothered to be honest, it's not something they seem to be concerned with and none have ever asked to have a look' (Manager CH 4, interview 3)

For their part residents and their relatives were as impassive to the outcomes of the inspection as they were to the inspection itself. Only one resident across the four cases studies had viewed the report by the end of my data collection, and this was at the request of her son. I also interviewed her son and it appeared the Hawthorne effect (Landsberger 1958) had an influence on his request from the manager to view the report:

'Yeah he came and asked me for it, he said he'd like to have a look, I think he knew you were coming back' (Manager CH 2, interview 2)

Other residents were indifferent to the findings because they either felt it was irrelevant to them:

'Oh I don't know about that (*the report*), I just get on with it, I'm ok that's what that I worry about' (Resident 1 CH 3, interview 2),

or they were concerned it would be too technical for them to understand and engage with:

‘Oh I don’t worry about that, that’s for them to worry about. They know what they’re looking for, let them get on with it’ (Resident 3 CH 3, interview 1).

These opinions suggest a prevailing notion of dependency and lack of empowerment, which mirrors the findings of the previous chapter. Residents were neither actively encouraged to engage with inspection outcomes nor empowered to do so. The lack of engagement with both the inspection process and outcomes is a failure of the CSCI as much as the service provider or resident. Studies in other fields, such as mental health, have shown that an understanding of processes creates concordance with processes rather than compliance (Gray, et al. 2002). Concordance is important because it realigns the power balance and empowers residents to actively engage with and control the outcomes they receive from services. In this study residents clearly showed compliance with both the service and inspection.

There was a common theme amongst the residents of devolving decision-making to their families, which further compounded a belief in dependency. This passivity extended to ensuring the quality of their care:

‘Oh me son worries about that, he looks after me you know, pays the fees and sees it’s all alright’ (Resident 3 CH 4, interview 1)

However, aside from one relative in CH 2 no other relatives viewed the inspection report over the nine month study period. This lack of engagement was particularly surprising considering I was questioning them about inspection and whether they had viewed the report. A lack of time was offered as a reason by most relatives and inaction was usually justified by contentment at the quality of service, as the son of a resident in CH 4 explained:

‘I don’t think I need to look at the report, I know that my mum is happy and that the care here is good. If I have a problem with something I go and see the manager and get it sorted out, but aside from one or two little things like a missing blouse, which, lets face it Matthew is going to happen in a big home like this, I’ve had no cause for complaint’ (Relative 2 CH 4, interview 3)

Surprisingly in CH 1 where two relatives had concerns about care and had been frustrated by a lack of progress in improving the service, neither had viewed the report. Relative 2 had a problem with access because she did not use the Internet and the service were not forthcoming with a copy:

‘well I did ask (*the manager*) for a copy, he sort of brushed me off, said yes, but then hasn’t been forthcoming with it. (*The inspector*) told me I could get it online, but I don’t use the Internet’ (Relative 2 CH 1, interview 1)

Relative 3 had concerns about the care but she did not look at the report because of time constraints:

‘Oh I haven’t got round to it you know, I guess I know what the issues are anyway’ (Resident 3 CH 1, interview 3)

There was a clear lack of engagement with inspection; reports are designed with service users in mind but are not being accessed by those who use the service or their relatives.

IMPACT OF INSPECTION OVER TIME

Satisfaction with service

During discussions about their experiences of care residents invariably inferred to their satisfaction with the service in terms of a concept of happiness. A typical response to discussions about their experiences of life in the home resulted in residents professing their happiness with the service:

‘Oh I’m happy here they look after me, make sure I’m ok’ (Resident 2 CH 3, interview 1)

In the simplest interpretations of the concept happiness infers a persons short-lived state, however residents’ used the term to describe it in a sense of life satisfaction and satisfaction with service (Donovan. and Halpern 2002). When discussing happiness residents focused on the support they received, no matter how limited, and the good things

in their life. They tended to dismiss or marginalise the aspects, with which they were less happy because they saw these as circumstances of their situation. For example, one resident explained:

‘Oh I’m happy, I mean I can’t walk anymore, but I have the DVDs and telly and I can’t get out much, cos of me legs but there’s nowt anyone can do about that so I can’t worry about it’ (Resident 1 CH 1, interview 2)

Another resident of CH 3 exhibited similar sentiment:

‘Oh I can watch the cars go by here and chat so I’m happy, I mean I cannae walk without the frame so I have to be happy with what I can do’ (Resident 3 CH 3, interview 1)

In this sense residents’ descriptions of their happiness were always described in the context of decay associated with the ageing process. The focus was primarily on physical decay, but also in a number of cases residents focused on issues of mental decay, such as loss of memory or increased confusion. This data mirrors the findings of previous studies on life in care homes (see for example Shaw 1984).

There was very little change in life satisfaction during the longitudinal study period. Resident 3 in CH 3 spoke in exactly the same way about her happiness on my third visit, as she did during the first:

‘Oh I’m happy, ay, just being here and looked after, with everyone to have a chat with. I cannae walk see, so I can’t really go out. Occasionally the staffs take me in a wheelchair like, but only when they have time... not very often’ (Resident 3 CH 3, interview 3)

Inspection had no direct positive influence on residents’ satisfaction during the case studies and this is not surprising considering the lack of both direct change to service delivery and change in general discussed in Chapter 5.

Negative impact of inspection on life satisfaction

The only reaction to inspection that had a direct effect on residents' happiness was the negative influence of a particular requirement in CH 4. The report required that the service stopped allowing residents to have their doors propped open because this practice represented a fire risk. This had a negative impact on all three residents I spoke with as they felt it created isolation, as Resident 2 explained when I asked about any changes to the service:

'Oh the door has to be shut, that's the big problem now. I hate being shut in my room, I like to see people go by, they stop and chat. See I mean some I know in here are on frames and they're frightened now to stand behind the door case they get hit' (Resident 2, CH 4, interview 2)

The lack of an open door was causing loneliness and exposing a lack of contact with staff, as Resident 2's daughter explained:

'I mean they don't even come round to check on them, at least when the door was open mum could see people, now she feels like she's in jail' (Relative 2 CH 4, interview 2)

Although this change had a negative impact on residents the problem could have been rectified relatively simply by the service. In order to adhere to fire regulations they were required to fix magnets to the bedroom doors that would release if the fire alarm activated. However, despite the relatively simple solution the problem had not been addressed for this resident by my final visit. The manager explained that the process to install the magnets had taken a long time, due to hesitation from the parent company and delays from the building company. However, the service had returned to propping Resident 1's door open while they were waiting for installation, risking the prospect of being caught by an unannounced inspection⁶. The service could have used this process to demonstrate personalisation by prioritising those residents who liked to keep their doors propped open. On my final visit plenty of residents had magnets on their doors, yet they preferred to keep them closed.

Satisfaction and criticism of service

It was very obvious that personal satisfaction and criticism co-existed for residents. Criticisms were often only implicit in the interviews, and where residents explicitly raised problems they had little effect on their satisfaction of the service. Problems were usually seen as a foible that they had to accept, often in the context of lower expectations:

‘I have to wait quite a bit for the staff... but, they’re good here and when you get to my age and you can’t do things like you used what else can I expect’ (Resident 1 CH 4)

Judgements about standard of service did not always correlate with satisfaction because of varying expectations and aspirations. This finding is similar to that of Rees and Wallace’s conclusions when discussing social work:

‘Client evaluations are not simply related to the receiving or not receiving of... help... They are related to context, to knowledge of services available, to expectations...’ (Rees and Wallace 1982: 72)

The residents provided positive evaluations of the service that were apparently influenced by frames of reference. When asked if they were happy with the service they received and their life in the home most answered in the affirmative, but when I asked where they would like to live all would have preferred to live in their own homes or with family. These discrepancies reflect residents’ perceptions of what is *possible* and what is *ideal*. The reluctance of residents to evaluate the service received can therefore be seen in the context of personal norms and expectations.

Residents focus on outputs rather than outcomes

In the previous chapter I discussed the influence of organisational structure in perpetuating ageist culture in services. This was both reified and justified by a focus on outputs rather than outcomes for residents. Analysis of interviews with residents suggests residents shared the staff focus. During both interviews with the inspector during the site visit and in the more in-depth interviews I conducted with residents it became apparent that residents tended to focus their evaluation of service performance on outputs rather than outcomes.

For example all four services offered a limited amount of activities, typically bingo and sing-a-longs, and these were not tailored to residents through consultation, but residents did not link these service outputs to outcomes:

‘Well I don’t do a lot, they have bingo and things, but I don’t enjoy that I don’t do any of the activities, like. I sort myself out I read and watch the telly... my son brings me books from the library’ (Resident 2 CH 4, interview 1)

Similarly residents spoke about a lack of staff and how this related to them having to wait to be assisted. But they did not link these directly to outcomes, which were interpreted as being the responsibility of the individual, rather than a collective responsibility of the service – managers, staff, residents and relatives. Residents focused on contact with friends and family to achieve outcomes such as social interaction:

‘(*Her son*) comes every Wednesday and I look forward to that we have a good chat and he helps out here you know. He makes a cup of tea and chats with the staff. He sometimes takes me out’

MN: ‘And what do you like to do during the rest of the week?’

‘Oh not a lot’ (Resident 1 CH 2, interview 2)

This led to a measurement problem for inspectors because strictly speaking outcomes should be measured subjectively based on whether residents feel their needs have been met and are ultimately satisfied.

It was often the aspects of their care that residents purposefully marginalised in the interviews that gave a sign of areas where the service could improve the lives of residents. Seemingly in the context of their feelings of decay and passivity were very reluctant to explicitly request or demand action in these areas. I focus on these issues in the next section of this chapter to try to determine if there were any changes to the care experienced by residents over the case study period.

Prevailing notions of deficit and deficiency

Limited expectations meant most resident's conceptualisation of care was very narrow, based on notions of deficit and deficiency in old age. This perception was unanimous across the residents interviewed. When I asked about outcomes they thought good quality social care should provide they focused almost solely on provision for their physical needs:

'They have to help me get dressed and with my bath... what else can I expect... if I can have my book to read and my friends come in I'm happy' (Resident 2 CH 4, interview 1)

This impression was reflected in the criteria they focused on when discussing well-being and satisfaction. Residents emphasised qualities they thought society deemed desirable in a care home: the environment and processes of physical care, issues that have historically been the focus of residential social care, and focused less on mental and emotional well-being because they were perceived as subjective and individual:

'Oh well I've got a lovely big room, it was originally meant for two people you know' (Resident 1 CH 1, interview 1)

None of the residents spoke of wanting a greater involvement in their care, and when I asked directly about this the subject it often was dismissed as unnecessary. Responses from residents of CH 2 and 4 represent the passive response to my questioning about further involvement in their care:

'Oh no, I leave that up to them, I wouldn't like to get involved, they're the experts and know what's best, no I'm happy with the care they give me'

'No they know what they're doing, they have a hard job, with a lot of residents to see and get up in the morning, I have no complaints'

Services provided within a political lens of new managerialism were supposed to change the problem of state-led service provision, which was characterised by public bureaucracies that created bureau-professional power over service users and marginalised choice and control (Mintzberg 1983). It is clear from data discussed in this chapter and the previous chapter that the concept of empowerment has yet to permeate all services and that

the technicalisation of the system of provision actually leads to similar types of bureau-professional hegemony over services that were characteristic of previous public service bureaucracies.

The influence of ‘culture of ageism’ on residents

In devising this research I choose to focus on services that were rated as either ‘poor’ or ‘adequate’ by the CSCI at the beginning of my case study. The rationale for this was that these services are starting from a standard of care that is failing to meet a number of NMS and so I hypothesised would receive the greatest impact from inspection and have the greatest scope for improvement.

Residents’ views of good quality social care suggest an endemic culture of ageing across all four case studies with residents subscribing to ageist attitudes that suggest they are frail and dependent. Conversations with residents always touched on frustration at having to wait for assistance, but this was tempered by their belief that their dependence was an inevitable consequence of their ageing and as such they had to accept the level of service they received rather than complain if they felt it was poor:

‘I wish I could just get it myself you see, but I can’t walk anymore, so I have to wait for them to help me’ (Resident CH 2, interview 1)

This opinion was ubiquitous across the four cases, where all residents I interviewed felt as though they had to make certain compromises and accept that they were in decay, as an interviewee in CH 4 describes:

‘well I can’t walk now, me legs have gone, so I have to accept I can’t go out much... not in the winter, me daughter will take me into the garden in the summer’ (Resident 1 CH 4, interview 1)

The feeling of dependence further compounded residents’ willingness to accept bad practice or treatment because they were afraid to complain, either in case it made things worse or for fear of upsetting staff on whom they relied.

This situation was typified by the residents in CH 1 and 4 whom did not like aspects of the way staff treated them but were prepared to accept the treatment because they did not want to 'rock the boat' and risk upsetting those on whom they felt they were dependent. For example, one resident in CH 1 was called 'Granddad' by 'one or two of the staff' (Resident 1 CH 1, interview 1) and although he did not particularly like it he put up with it because he did not want to 'rock the boat', so did not complain. His hesitancy seemed to be the result of a lack of empowerment compounded by a negative conception of ageing that had resulted in him acquiescing to the very staff who were paid to care for him.

These findings echo Goffman's concept of the total institution where:

'... all aspects of life are conducted in the same place and under the same authority... each phase of the member's daily activity is carried out in the immediate company of a large batch of others all of whom are treated alike...'
(Goffman 1991: 17)

The findings suggest that despite ongoing improvements inspection has failed, both practically through system changes and ideologically through new managerial discourse, to have sufficient impact on some services to completely eliminate the institutionalisation of residents.

A self-perpetuating model of care provision

As described in the previous chapter this outdated conception of care stemmed from a poor, ill informed, service and was self-perpetuating. Residents, and relatives, had low expectations because they had not experienced a better model of care. None of the case studies exhibited an innovative model of empowerment for residents. Only one resident across all four cases had seen her care plan, let alone discussed a plan of care. This was telling when considering residents' responses to my questions about outcomes delivered by care services. As residents were not exposed to processes of empowerment they were largely unaware of the existence of methods to co-produce their care, so consequently did not expect to be empowered.

CHANGES RESIDENTS WANTED TO SEE TO THEIR CARE: INDICATORS OF IMPACT

During interviews with residents I tried to determine, both through direct questions and analysis of their experiences of living in the care home, any changes they would like to see to the service. I then followed up the issues raised to see if the service had made the changes, and if so if it was possible to determine the reasons for the change.

There were common changes residents wanted to see across the four case studies, so they are presented here in themes. There were a number of specific issues or complaints from residents that, while different in detail, fall under the same crosscutting theme. In order to examine the impact of inspection I describe any case specific changes over time, within the thematic analysis. Appendix 8 shows a tabulated service-by-service breakdown of changes residents wanted to see and tracks whether these were addressed over the case study period.

As residents tended to focus on service outputs in the interviews their focus for change was also on outputs. In the interviews I tried to explore how the outputs affected outcomes for residents and in this analysis I make these links.

I ensured that at least two of the three the residents I interviewed in each case study also spoke with the inspector during the site visit in order to determine if the inspectors had any direct influence on individual service users care.

Lack of staff

Almost all of the residents interviewed during the four case studies felt there was a lack of staff. Staff were seen in both a technical sense, as aides to support the physical practicalities of daily living, and a point of human contact. Residents' mainly attributed a lack of maintenance and support as the consequence of staff shortages, but it became clearer that this issue had wider ramifications in terms of personalisation and associated outcomes older people have identified as important: feeling valued, having a say in service delivery, control over routine (Glendinning, et al. 2006).

The tendency was to speak of the need for an increased number of staff, rather than criticising the current staff for not being efficient enough:

‘Oh I think they need more staff, the ones here do such a good job, but they’re run off their feet’ (Resident 1 CH 2, interview 1)

‘Oh the staff here are great, they work so hard, I just wish there was more of them... it’s for them really, they never sit still you know’ (Resident 2 CH 3, interview 1)

The balance between the expectations of residents and resource limitations of the service is difficult to judge, as the Line Manager of CH 2 claimed:

‘Residents are always going to want more staff until they have one to one care, that’s natural and in an ideal world we’d all like to be able to offer one to one care, but the reality is that we can’t, unless you are prepared to pay for it... we do the best we can and we do an assessment every 6 months based on Skills for Care guidelines’ (Line Manager CH 2, interview 3)

Despite his claim to do regular assessment of staffing levels CH 2 was the only service issued with a requirement to re-examine their staff numbers and skills mix. As discussed in the previous chapter the Line Manager did not change this because he claimed he regularly conducted an assessment of staffing based on Skills for Care guidelines (which were endorsed by the CSCD):

‘It’s the agency staff you see, and I accept they don’t always know the residents, but what can I do if someone calls in sick? When we have our regular staff on we are fine, but I can’t wave a magic wand if one of my staff calls in sick half an hour before their shift’ (Line Manager CH 2, interview 3)

This method, which is non-prescriptive, inevitably leads to tensions between inspectors’ judgements, managers’ judgements and service users’ views.

The two residents in CH 2 spoke of a lack of staff causing long waiting periods for assistance during my first visit. This was still a problem by the third data collection point and was still clearly having a negative impact on their well-being, mainly in terms of long waits for physical assistance:

‘It’s been a bit up and down, there has been quite a shortage of staff and that does alter things because they’re late with everything, especially get up in the mornings’ (Resident 1 CH 2, interview 3)

‘we have to wait for everything and the agency staff don’t know you or what you want or anything so it’s not pleasant at times’ (Resident 2 CH 2, interview 3)

Residents in CH 3 also suggested a lack of staff was leading to lengthy waits for assistance to complete necessary daily tasks:

‘Oh I often have to wait a while to get up of a morning it sometimes takes an hour from getting up to being ready and down here, there’s not enough staff to do it on a morning’ (Resident 1 CH 3, interview 1)

‘Sometimes when I need the toilet they make me wait, I’ve had accidents before you know’ (Resident 3 CH 3, interview 1)

These were clearly related to the technical aspect of care rather than providing social contact, which in CH 3 residents perceived as being good:

‘I have fun with the carers, a chat you know, I liked to take the micky...if I stayed at home I’d be on my own watching traffic... the staffs have always got time for a natter, and they often bring in the bairns, which is good like’ (Resident 1 CH 3, interview 1)

The inspector of CH 3 did not require a review of staffing levels and there was no change during the study period despite residents concerns about the time they had to wait for assistance, which, in the example of a resident having to wait so long for the toilet that she

wet herself, resulted in unacceptable lapses in the quality of care, which the inspection process failed to uncover.

In CH 4 two of the residents I interviewed felt there were lengthy waits for assistance when they rang the call alarm, as Resident 3 explained:

‘I do have to wait a long time, they often come in and say, ‘I’ll be with you in a minute (*Resident’s name*)’ and then they don’t come back for over half an hour. I often have to ring the bell again’

MN: ‘Doesn’t it just keep ringing?’

‘No they come in and switch it off when they check on us’ (Resident 3 CH 4, interview 1)

Once again there was no change to staffing levels over the study period. The inspector judged the service to have an adequate number of staff with an appropriate skills mix so did not require a review of staffing. Unsurprisingly according to the residents the waiting times had not changed and they were still regularly waiting quite long periods for the call alarm.

In CH 1 where the inspector did not issue a requirement for the staffing levels to be re-assessed an additional member of staff had been added to the afternoon shift. Two of the relatives thought this had made a small difference to the quality of their care:

‘you see they’ve got an extra member of staff on in the afternoon and I think that has made things improve slightly... I arrive to her being wet quite a bit less than I used to, although it’s still far from perfect, but small steps ey’ (Relative 2 CH 1, interview 3)

‘They seem to have a bit more time now. I don’t think they’re as stretched as they were but they still don’t have a lot of time to spend with mum, which is to be expected I guess there are a lot of residents with a lot of problems here’ (Relative 3 CH 1, interview 3)

Relative 2 had seen small improvement in her mother's hygiene, which she directly attributed to there being more staff in the afternoon. As the inspector made no reference to staffing levels the change cannot be attributed to inspection. Relative 2 and 3 felt the change had come about because of complaints they had made to the manager. The staff in CH1 also felt they had an impact on the change:

'we've got an extra member of staff now... its taken a while. A lot of fighting from me and (*another staff member*). We've finally made him (*manager*) see sense. I think some of the relatives have also been working on (*the manager*), I know (*Relative 2*) has been asking for another one on in the afternoons for a while' (Staff 2, interview 3)

However, interviews with staff suggest that the new member of staff simply facilitated a continuation of basic levels of care, rather than enhancing the service:

'We've finally got an extra member of staff on in the afternoons'

MN: 'And that's made a difference to the service you provide?'

'Well it means we can cope, we can toilet them all now whereas it was becoming difficult to even do that before' (Staff 1 CH 1, interview 3)

The evidence from staff was also supported by resident 1's (CH 1) experience. At the beginning of the study he complained that:

'(I) hardly ever see a member of staff except when they bath me or bring me my food' (Resident 1 CH 1, interview 1)

After nine months he felt this had not really changed despite the additional afternoon staff member:

‘I still have days when I might only see them when they come to do things for me, you know they never just come to say hello or for a chat...’ (Resident 1 CH 1, interview 3)

The data suggests the extra member of staff had eased the burden of care, but had failed to increase the amount of social contact staff had with residents.

The findings suggest questions about the appropriateness of CSCI guidelines on staffing levels and whether there is enough investigation into the ability of staffing levels to fulfil the demands of the service users. The levels of waiting described in all services was often lengthy and clearly a cause of distress to residents. Despite this fact only one service was issued with a requirement to review staffing levels, which the manager ignored as he felt he was already doing so.

Poor personalisation

Residents did not talk directly about the planning of their care but a number of their direct grievances were the result of lack of personalisation and planning. This theme spanned the four case studies and was represented by a number of different issues.

Lack of consultation

In a clear sign of poor personalisation and care planning in CH 1 Resident 1 felt he *had* to drink a cup of tea everyday:

‘Sometimes I don’t really want a tea but I don’t like to say no, cos once or twice I have and they haven’t brought me another one for a while’ (Resident 1 CH 1, interview 1)

Rather surprisingly the same problem was experienced by Resident 1 of CH 4, as we discussed during the first interview:

MN: Shall we stop talking for a while so you can drink your tea?

‘Aye I suppose we should, I don’t really want it like, but I’d better drink it’

MN: ‘why not just leave it?’

‘Nor cos then they’ll think I don’t want it and stop bringing it’

MN: ‘Has that happened before?’

‘Oh aye and then it took me ages to catch a carer at the right time to tell her I wanted one at 10 o’clock’ (Resident 1 CH 4, interview 1)

Neither issue had been resolved by the end of the study – both residents were still stoically drinking their tea every morning. There was no evidence of improved care planning in either case. The inspection report for CH 4 did not contain a requirement for improved care planning, so no change was required by the inspector and the manager claimed there had been no changes made to care plans during the study period. However, the inspector of CH 1 did issue a requirement that care plans were improved, but the resident did not notice any change in service:

‘Oh no they never ask me if I want a tea, they just bring it’

MN: ‘And is that ok?’

‘Well I sometimes don’t want it but I drink it anyway cos when I’ve said no in the past they have stopped bring it for a while, and most days I do want a cup’ (Resident 1 CH 1, interview 3)

Residents’ experiences mirror findings in the previous chapter which show that there had been no changes to care plans during the study period, although the manager of CH 1 claimed to be in the process of hiring someone to help re-develop them during my last visit to the service. A simple change like asking residents if they wanted a cup of tea each day rather than assuming could be made very easily, but despite requiring care plans to be reviewed there was no change to residents’ experience of service. The impact of the report was not sufficient to induce changes to working practices to improve personalisation.

In a further example of poor personalisation Resident 1 of CH 4 also wanted the opportunity to take part in some of the activities the service offered. She had developed a reputation for preferring to stay in her room during the day because she did not want to sit with the other residents or play bingo. However, occasionally the home hosted a sing-a-long, which she was often not even told about because staff presumed she would not want to attend:

‘... well they occasionally have a sing-a-long, but they never tell me about it’

MN: ‘Would you like to go to that?’

‘Well I would aye, but they never tell me’ (Resident 1 CH 4, interview 1)

As with the lack of personalised planning for her mid-morning drink this issue had not been resolved by the end of the study and she was still not attending any of the activities the home put on. There was a clear clash of regime cultures in the way homes addressed these issues through an organisational routine - a notice or mass announcement – but the residents respond as individuals and expected to be notified personally.

A lack of personalisation was also experienced by Resident 1 of CH 2, who felt she had to fit in with the routine of the service and go to bed at eight o’clock every night. She was never asked by staff if she was ready to go to bed, but simply taken to her room as part of the bedtime routine:

‘I have to go to bed at eight you see’

MN: ‘And would you prefer to stay up later?’

‘Well maybe sometimes

There was no change to this routine over the study period. The resident had made a decision to go along with the routine rather than request to stay up later on occasion:

‘Oh I’m sure I could ask to stay up later, but I don’t want to cause a problem you see, they’re busy enough as it is’ (resident 1 CH 2, interview 3)

As well as a lack of personalisation in care planning by the home there was also a clear lack of empowerment of residents across the four services. The services were still exhibiting a rigidity of routine and process of block treatment that Goffman found in the 1950s (Goffman, 1991). Further evidence of institutionalisation is demonstrated by the fact that not one resident in any of the four case studies was prepared to make a direct complaint to the service about an issue of personalisation. However, both insisted they would speak up if there was a more ‘serious’ issue, such as physical mistreatment, but not on a matter of personalisation. As the Resident 2 in CH 4 explained:

‘well I’m not going to rock the boat, its not that important. I’ll just keep quiet about it haha, its only a cup of tea...’

MN: ‘So you don’t complain if you have problem with the service?’

‘Oh if they shouted at me or treated me bad like, I’d tell the manager yeah’
(Resident 2 CH 4, interview 1)

The residents showed a clear hierarchy in their perception of care services, with support for keeping alert and active regarded as less important than assistance with physical care or safety. The other services, like being brought a cup of tea were regarded as ‘extras’, provided generously by busy staff, but not a right.

Lack of choice of food

Previous research by Cass et al (2006) and the CSCI (2006a) have shown how much importance older people place on mealtimes, and according to a report by the CSCI they are often ‘the highlight of the day’ (CSCI 2006a: 3). A choice of food is one of the ways in which CSCI judge if service users are being offered choice and control.

In support of this evidence where there was a lack of choice offered in CH 1 and CH 3 residents wanted to see improvement because they valued meal times highly. In CH 1 the lack of choice particularly upset Resident 1:

‘It’s always bloody sandwiches for tea, I get sick of sandwiches. It’s never anything hot... I get (*his daughter*) to bring me food in the evenings sometimes cos I get so sick of sandwiches’ (Resident 1 CH 1, interview 1)

A lack of choice and control about her food was also an issue for Resident 2, but as a series of extracts from the three interviews show, she exhibited resilience by finding a way to cope with the problem:

Interview 1

‘I never had a banana this morning’

MN: ‘Oh really and you usually do?’

‘We have a cup of tea, bread and butter and a banana. I’ve got it all in me little book, me diary. It’s all what I had for me meals you see’

MN: ‘Oh so do they ask you what you would like?’

‘No I just go back a week, its nearly always the same, but no banana today’

Interview 2

MN: ‘So do you still keep a food diary?’

‘Oh yes’

MN: ‘And is it still more or less the same every week?’

‘Yeah, usually’

MN: And nobody comes to ask you what you would like?

‘No, I just check in me diary’

Interview 3

MN: ‘So do you still keep a food diary?’

‘Yeah I do’

MN: ‘And is it still more or less the same every week?’

‘Yeah, I like to be able to check you see, so I know what I’m having’

MN: Do you ever wish it would change?

‘Well sometimes, but I like to know what I’m getting see. I can just look in me diary’
(Resident 2 CH 1)

The resident clearly would have liked to have been told about her food menu for the day, and as the extract from the third interview shows she would have liked to have a choice, but the repetitiveness of the weekly menu meant she was able to develop a coping method to find out what her food was likely to be that day. In the final interview she admitted she would like more choice. The fact that she also kept a diary suggests the service was failing to keep her informed and certainly failed to offer her any choice over the food she received. The tendency to find coping solutions in response to poor outcomes around personalisation was a feature in the case studies and one which inspections failed to have any impact on improving.

CH 3 also offered a lack of flexibility in food provision specifically in relation to Resident 2’s diabetes:

‘You know just occasionally I’d like a cream cake for desert like the others, but they say I’m not allowed cos of me diabetes. Well I’ve had it for twenty five year (*sic*) and I know I can have a cream cake sometimes... I’m the one who the nurse comes to see to check me blood sugar’

This paternalistic control was incredibly frustrating for the resident, who felt she could manage her diabetes herself given her long experience of living with the condition. This had not changed by the end of the case study period, as she still felt as though she was being denied an occasional treat:

‘Oh no I’m still not allowed me cakes, they say they’re no good for me but I’d like the occasional one’ (Resident 2 CH 3, interview 3)

Lack of activities / stimulation

Residents across the cases complained about having a lack of things to do:

‘Oh I’d like to be able to do more, get out and go to the shops or have a walk, but it’s these things see (*points to legs*). I can’t walk very far and I need this (*pointing to walking frame*)’ (Resident 1 CH 4, interview 1)

or getting bored

‘Oh I get bored quite a lot, we have a telly there but I don’t really watch it, I’m partially sighted you see...’ (Resident 2 CH 2, interview 1)

Academic studies show boredom is a key facet of care home life because residents are usually restricted in their mobility, which often limits the amount they can do for themselves (Hoe, et al. 2006). This is why the CSCI places an emphasis on the service providing activities and stimulation. Of all the residents interviewed across the case studies only one resident from CH 3 (Resident 3) did not claim to get bored or express the desire for more activities to be provided by the service.

These complaints were not explicitly directed at service failings, but rather once again focused on perceived and real notions of disability and decay in older age:

‘... I can’t do much you see so I just sit here and talk to people, when they come in’ (Resident 2 CH2, interview 1)

This depression and resignation associated with her old age also frustrated her son:

‘we’d love for he to come home for a visit but she won’t, on the basis it will upset her... I can’t fault the staff I mean they try, but there is a limited amount they can do’ (Relative 2 CH 2, interview 1)

MN: ‘Do you think they do enough?’

‘I’m not sure what else they could do if mum is unwilling’

However, the resident admitted she might have joined in with some of the activities had the service been more proactive at including her. She spent her days in a small communal room that was not used for activities:

‘I’m not bothered about the bingo and sing-a-longs. I don’t see them so I’m not bothered’

MN: ‘But what about if they did them in this room?’

‘Oh well I might do them, but I’m not bothered really’ (Resident 2 CH 2, interview 2)

The resident had settled for this situation and because she was frustrated at the physical decay of her body and felt it was something that she should endure. The service had made limited attempts to include her further but had not managed to find an innovative way to encourage her inclusion. Despite this the inspector of CH 2 judged the provision of activities to be good and there was no improvement over the case study period.

Resident 2 in CH 3 had a specific complaint that she was not being included in activities because she was partially sighted and therefore could not play dominos or bingo. The inspector made a requirement for there to be more done for partially sighted residents, but Resident 2 felt nothing had changed since the inspection:

‘Oh nah, they’re not doing anything for me like, they still play bingo and I’d like to join in, but how can I when I can’t see the card?’ (Resident 2 CH 3, interview 3)

Resident 1 of CH 4 were also left frustrated by the unimaginative activities that did not appeal to her and consequently meant she spent a lot of time in her room:

‘Nah, they bore me all the things they do, I’d prefer to stay here and read or watch the telly... oh I used to do a lot in my last place (*a supported living facility*), darts, carpet bowls, I used to love carpet bowls, but they don’t do it here’

MN: ‘Have they ever asked you what you might like to play?’

‘Nah I just let them get on with it, others like what they do’

And this did not change over the case study period:

‘Oh nah we haven’t played anything like that, I like to just sit and read, or watch the telly’ (Resident 1 CH 4, interview 3)

As with CH 2 the inspector judged the provision of activities to be good in CH 4, so there was no requirement to improve this aspect of care from the CSCI.

There were some signs of improvement in activities and stimulation in CH 1, where the inspector issued a requirement that activities were reviewed. In the first round of interviews Relative 2 thought her mother, who could no longer verbally communicate after a stroke, was neither mentally nor physically stimulated:

‘I don’t think they do enough to keep mum ticking over, you know, rather than just letting her sit there. It would be nice if they had a bit more time to talk to her or do something with her’ (Relative 2 CH 1, interview 1)

As a result of the requirement an activities co-ordinator had been appointed on a part-time basis and there were noticeable, but limited improvements:

‘Well there does seem to be a bit more going on now, things like catch ball. Its quite limited but it’s a start and mum joins in which is good’ (Relative 1 CH 1, interview 3)

‘This new activities person does try to spend some time with residents, especially those who can’t do a lot like mum’ (Relative 2 CH 1, interview 3)

Instances where residents attribute changes to inspection: Inspectors intervening directly in specific cases

Over the course of the four case studies there were only two instances where an individual resident identified inspection as having a direct impact on their care. These were both instances where the inspector intervened directly on a specific issue of poor care.

The first occurred in CH 3 when the inspector spoke to the manager about a direct complaint a resident made about a particular member of staff whom she felt did not treat her with enough respect. This was dealt with by the manager and the resident was happy the staff member had improved by the third point of my data collection.

The second direct intervention came in CH 1 where the service was neglecting to replace a resident’s asthma medication despite the residents persistent questioning. The inspector spoke to the manager about this during the inspection and it was resolved quickly, although the residents’ daughter also spoke to the manager about the issue. As it was a medication issue I asked the inspector why this failing had not resulted in a direct requirement issued in the report. The inspector claimed that because the resident’s asthma medication was self-administered he would only speak to the manager and ask him to resolve the problem, if it had been part of the medication the service was responsible for dispensing he would have issued an immediate requirement to the home.

Frustration at lack of change from relatives

In CH 1, where there had been a history of missed requirements over a number of inspections, relatives were disillusioned with inspection and it’s lack of power to enforce:

‘I just don’t think they make sure that what he says should be done has got to be done... (*the inspector*) is very good but I suppose his hands are tied... the government should have more weight’ (Relative 2 CH 1, interview 1)

‘I’ve told the inspector before about my problems and nothing changes, they (*inspectors*) don’t seem to do anything’ (Relative 3 CH 1, interview 1)

Relatives in CH 1 had a number of issues regarding the number of staff on duty, the attitude of the manager and his ability to make improvements and although they had not viewed inspection reports, as far as they were concerned there had been no impact from previous inspections. By the end of the study small changes were beginning to occur in terms of improved communication but these had only been small. They clearly attributed this to a lack of enforcement ‘power’ to force change.

A paucity of impact on residents

Analysis of the data suggests there are four ways in which inspection can induce change:

1. Indirect influence on outcomes, through changes to the ‘culture of practice’
2. Indirect influence on outcomes, through inducing changes to paperwork and changes in process.
3. Direct intervention to improve outcome(s) for all residents as the result of a particular general failing, e.g. medication.
4. Direct intervention to improve outcome(s) as a result of an individual’s complaint at time of inspection or bad practice uncovered by the inspector.

As I have described through this chapter the impact of inspection in each case study was relatively limited. At first this seemed surprising considering the homes were rated as either ‘poor’ or ‘adequate’ by the CSCI and therefore were identified as in need of immediate improvement. There appeared to be a number for reasons for this paucity.

First, most of the requirements to improve issued by inspectors fell under ‘indirect influence on outcomes’ and therefore had a limited direct effect on residents. They were related to the process of running a care home: paperwork or environment issues. Changes in these areas needed time to produce direct changes visible to service users. An example

was the change in attitude of the manager of CH 1 by the third data point. This had no discernable immediate effect on residents' care. However, there was an indirect effect in terms of improved listening and consultation by the manager of CH 1, and this change was noticed and appreciated by residents and relatives. The staff I spoke with at the third point of data collection thought that small improvements in communication had improved the atmosphere in the home which had in turn meant staff were happier and working better as a team:

'...yeah... I mean it's been small and there's... he's still got a long way to go with how he talks to us, but it's definitely got better, he's now listening to us about things... and for example we now have an extra member of staff on in the afternoon, when before there only sometimes used to be one for two hours between 2pm and 4pm there is now two and sometimes three' (Staff 1 CH 1, interview 3)

This method of indirect change is increasingly the predominant method of improvement for the CSCI, as it evolves into a system with a greater emphasis on audit – checking the systems are in place on the premise that with the right systems services will provide high quality care. This rationale is clearly not working as the CSCI would like because, certainly in services performing poorly against the standards, it is not fostering the level of improvement care home residents would like.

Secondly, the inspection process had a limited impact on the culture of practice within the services. It appeared that without this embedding of good practice through persuasion and education the services were failing improve the process of care. As discussed in the previous chapter services were resistant to change because the management either disagreed with the judgement of the inspector, did not have the knowledge to carry out the changes, or did not have (or would not spend) the resources to make the change. Without the embedding of prevailing notions of good practice more direct changes were resisted by the services because they were seen as unnecessary.

Thirdly, the changes residents wanted to see did not always tally with inspector's judgements. This was particularly the case with residents concerns about the lack of staff. The issue of staffing was far from clear-cut and represented an aspect of inspection where inspectors would not directly intervene, but instead ask the service to review their current

plans. In the case of CH 2, where this requirement was issued, the manager simply chose to ignore the requirement because he felt they were already reviewing staffing levels appropriately. As there was no direct judgement on the acceptability of the current level the manager felt able to simply ignore the requirement and that at the next inspection he would argue that the service had regular staff reviews.

Fourth, the inspector failed to uncover service user complaints. This was particularly the case with some of the issues of personalisation and was related to residents' hesitancy to be open with the inspector and the relatively short amount of time inspectors have to speak with residents.

CONCLUSION

It was clear that service users and relatives knew very little and in most cases nothing at all about the CSCI. This finding alone poses an immediate difficulty for one of the central policy platforms of the CSCI, underpinned by a concept of active citizenship: that it should enhance service users' involvement in the social care process, and should make decision-making about quality more transparent. Neither of these aspirations has been delivered thus far by the CSCI. Indeed, there is some evidence that, ironically, it may have led to some loss of user engagement and involvement. This may be due partly to the fact that service users view the CSCI as complex and time consuming, and feel marginalised by outdated concepts of ageing that suggest they should be grateful and passive recipients of care rather than empowered to effect decisions about the provision they receive. It is also partly that inspection appears to have relatively little direct impact on service users; either not focusing on the outcomes they see as important or making very little difference to their experience of care home life.

There is a body of literature, including research done by the CSCI itself (CSCI, et al. 2006), that suggests ageism still exists within many older peoples services, despite work by the government, national regulator and workforce regulator (General Social Care Council). The findings in this study suggest that inspection by the CSCI, as the national regulator, has failed to induce improvements in the organisational culture of the service providers. Despite an ideological political shift in recent decades towards provision built on new managerial foundations that emphasise choice and control through service user

empowerment has yet to filter through to real service user control or empowerment in these case study services.

The implementation of these policy and cultural changes to provision might affect changes in the expectations of residents living within the care homes by exposing them to opportunities to exert choice and control as stakeholders able to contribute to the community rather than being passively resigned to decay and dependency in old age, but this cannot be judged using data from these case studies.

CHAPTER 7: THE CHARACTERISTICS GOOD QUALITY INSPECTION?

INTRODUCTION

This chapter follows on from the conclusions of the systematic review, and examines the facets of good quality inspection through the synthesis of themes from the previous two chapters and additional analysis of interview data from across the stakeholder groups.

Hood et al (1999b) developed Green and Welsh's (1988) cybernetic theory to analyse organisational control processes into a theoretical framework to test the usefulness of inspection of public service agencies. They divide inspection into three distinct elements: the director, which sets the standards and protocols; the detector, which gathers the information; and the effector, which modifies behaviour. This model provides a useful way to frame the data to determine stakeholder views on good quality inspection, how it could be improved and identify any tensions that exist within the system.

DIRECTION: ORGANISATIONAL INFLUENCE

The role of the CSCI as the 'director' of regulatory policy, working in conjunction with the Department of Health has been explored in the literature review of this thesis. This director influence in terms of internal CSCI policy development was a key source of tension during the interviews because the modernising policies of Inspecting for Better Lives (IBL) (CSCI 2005a) were being introduced during the early part of my case studies (April 2007). Documents such as the Inspection Record (IR), and the Key Lines of Regulatory Assessment (KLORA) guidelines, which prescribe the way judgements should be made against the national standards, and the new Annual Quality Assurance Assessment (AQAA) had all recently been implemented. This led to criticism about technical aspects of inspection and questions about the implications this modernising agenda had for the goals and purpose of the regulator.

The role of inspection

Data from this study, in agreement with other literature (see for example Hudson 2006), has already established that the broad goals of inspection are correct. Questions regarding the function of the CSCI led me to ask whether the various stakeholders thought the government should have a role in holding services accountable and ensuring they operate for the safety and well-being of their residents. The answer was obviously 'yes', with none of the stakeholders I interviewed believing inspection was unnecessary. In fact all four managers were keen that inspection should continue despite their grievances with both the process and outcomes. They felt it legitimised their service in the eyes of the public and provided a safety net to protect against bad care. The CSCI serves to give the public confidence in the system of care, despite evidence from this study that suggests they do not read reports or other CSCI publications. This point was highlighted by the regulation manager of CH 1:

‘Of course they want us to keep inspecting, it legitimises what they do and keeps the public thinking things are safe’ (RM CH 2)

The role of the regulator in the reassurance of the public was proven by the responses of residents and relatives in the study, who when asked about the need for inspection, tended to say:

‘I think there should definitely be inspection ‘cos who’s going to know if everything’s right unless they come and look’ (Resident 3 CH 3, interview 1)

Justification of its role

The priorities of an inspectorate are partly self-fulfilling, driven by its own goals and interests and those of the policy makers it serves. They also inevitably have to justify the belief that inspection is a worthwhile exercise. The CSCI had to justify its worthiness and progress to parliament each year (CSCI 2009) by making claims of improvement amongst the services it regulated. This point was raised as a complaint by managers and staff across the case studies who felt that some of the paperwork was only necessary to satisfy the CSCI rather than have any positive effect on the service:

‘I mean I really think we’re getting to the stage now where I’m questioning whether we’re actually running this home for the service users or the inspectors’ (Manager CH 3, interview 3)

‘...I’ve actually had residents complain about the changes we’ve made in response to the report, and I want to see what (*the inspector*) says when I tell him this next time. I mean I thought inspection was for the residents, so if they don’t like the changes what’s the point in them Matthew?’ (Manager CH 1, interview 3)

A similar complaint has been levelled at other public service inspectorates, notably Ofsted, the schools and children’s services inspectorate, who have been accused of inspecting and enforcing standards around managerial targets that are clearly to the detriment of learning (Lupton 2005). It was clear from interviews with inspectors, managers and staff that some standards were to the detriment of residents’ care, for example the increased amount of paperwork clearly reduced the time staff could spend engaging with and caring for residents. There is a clear case for documented audit trail to ensure accountability and safety. However, the evidence from these case studies suggests this has reached an extent where it is becoming detrimental to care.

From inspection to audit: The shift to risk based inspection in the name of modernisation

The CSCI has been working towards a model of regulation based on risk assessment since its inception. The idea is that inspections are targeted based on a record of performance and not all services are at equal risk of performance failure. As the Regulation Manager of CH 2 explains:

‘I mean it makes sense to target the services that have a poor record and are therefore quite rightly thought of as a higher risk... in a world where we have less resources targeting comes into play’ (RM, CH 2)

This lighter-touch approach is led by the data from previous reports and reviewing regular management and quality assurance data, which is provided in the form of a new self-assessment AQAA that was introduced just as I began my case studies in April 2007 (which meant it had not been used by the inspectorate at that point). The inspectors are

tasked with examining this data and looking out for any warning signs or ‘triggers’, which might signal the need for an inspection. In the case of services rated ‘good’ or ‘excellent’ an inspection might only be every third year unless data from the AQAA, or complaints flags the need for an earlier site visit.

This risk-based system was only introduced in 2007, rather than at inception, because the CSCI needed a period of ‘bedding in’ to understand the field and create a baseline for services. Only once there was a history of inspection and an accurate quality rating in place that can be traced over a number of years could the risk-based inspection be introduced:

‘We couldn’t have done it (*self-assessment*) any sooner or we’d have no decent data on which to base the risk assessment calculations’ (Inspector CH 2)

All of the inspectors expressed a concern about what they saw as a gradual shift towards auditing rather than inspecting. They saw the increasing amount of time they had to spend looking at paperwork during and inspection as indicative of this shift:

‘I mean with the new changes we’re moving from an inspection, where we spend time looking at the service to an audit where all we do is look at paperwork, and that’s the way its going to go further with the AQAA and new link inspector system’ (Inspector CH3)

By ‘auditing’ the inspectors were inferring a streamlined process that focused on examining and checking the accuracy of records, rather than an examination of the whole service, which they saw as the purpose of ‘inspection’.

The inspectors had three main concerns about the shift towards a system of regulation with a greater emphasis on audit. The first came from a position of self-preservation, in that they feared that scaling back of inspections might lead to job losses within the units and at the time of my data collection this was a real concern amongst inspectors:

‘We’re just not sure that it (*shift to inspection every 3 years for best services*) will happen... erm... but there is a real worry that there might be scaling back’ (Inspector CH 1)

The fears latterly transpired to be untrue (with losses being the result of retirement or staff leaving) but were a real concern during the early part of the case studies. This was a real and current anxiety for inspectors, which had an influence over their criticisms of the process.

The second concern was one of a decrease in the quality of service as a result of a change in the system of inspection. The inspectors were afraid that a shift to regulation with an increased audit element, at the expense of site visits, would compromise the quality of services, which the inspectors felt they had been making great strides to improve. Inspectors of CH 3 and 4 talked negatively of the differences between what they saw as ‘assessing’ and ‘inspecting’:

‘Assessing isn’t enough; we need to be out there with the people who matter. They need to know we’re out there and we need to know we can make them improve. I think we’ve taken a step back, especially now we don’t handle complaints’
(Inspector CH 3)

Inspectors felt these changes represented a further step away from compliance-based approaches and with it any chance of working with services to help them improve:

‘I mean my tendency has always been to talk with the services and give them advice, that’s what we used to do in the old days, but things have changed now and were not allowed to do that’ (Inspector CH 4)

The changes clearly made inspectors feel their skills and professionalism was undervalued:

‘Its changed an awful lot in the last 12 months... currently I inspect, but whether that will remain my role I don’t know. I think I will be assessing data rather than inspecting in the near future’ (Inspector CH 1)

There was a clear shift from inspection focusing predominantly on site visits to being based at a desk assessing paperwork. The prospect of assessing provoked thoughts of Braverman’s (1975) concept ‘de-skilling’, especially when coupled with the prescription

over judgements introduced by KLORA. This prospect was anathema to the inspectors in all four case studies and the inspector of CH 1 even suggested he would leave his job:

‘A lot of our role has been taken away now in terms of registration, not attending adult protections. My role is a lot more boring now... I’m not sure I’ll stick it out if it changes as much as it looks like it will’ (Inspector CH 1)

Concerns voiced by the inspectors reflect the wider debate about the role of the regulator and whether it should be a universal inspector, annually visiting each service irrespective of previous quality rating, or whether it should shift towards a more risk-based approach that uses past data, self-assessment (AQAA) and other statistical tools to identify risks and act appropriately.

The consensus of opinion was frustration at a shift towards what Power (1999) terms ‘ritualistic verification’, where the pattern of inspection is legitimised through standardised processes that produce consistent performance measures. In creating this functioning inspectors felt that the CSCI was losing sight of the goals of inspection. As Power (1999) explains:

‘Even though audit files are created, checklists get completed and performance is measured and monitored in even more elaborate detail, audit concerns itself with auditable form rather than substance’ (Power 1999: 96)

The inspectors believed money to be the primary reason for the shift, before any notion of more efficient or effective working. As the inspector of CH 4 rhetorically answered to a question about the changes:

‘Well its all about money isn’t it? At the moment I am frightened by the way it is going... KLORA is directing our judgements so we will always have to choose from a written judgement and I want to retain mine, not choose from judgements written by other people’ (Inspector CH 4)

Inspectors’ views are supported by analysis of CSCI budgetary data. Under a directive from the Department of Health the CSCI adopted a three-year financial strategy in

conjunction with IBL, resulting in £7351000 of budgetary cuts in 2006-2007 and the number of inspections dropping from 41599 to 23351, leading to £12527000 of savings in 2007 - 08, with a reduction in the number of inspectors from 1994 to 1844 between 2007 and 2008⁷.

Inspectors all spoke of being drawn to their previous work as social workers or nurses because of the relational and caring aspects of the work and they used this same rationale to justify their role as inspectors. This has been found in other recent studies of social work practitioners (see Carey 2003). Inspectors, like social workers, have to meet organisational demands, which have only increased with modernisation and commercialisation of these services. These demands have led to a decrease in the relational aspects of their work, certainly in terms of working in partnership with service providers and put their professional ethos at odds with the modernisation agenda of the CSCI. This situation had clearly created dilemmas for inspectors as they have a tendency to want to help and assist services based on their tacit knowledge and experience, but are constrained by the bureaucratic and hierarchical settings within the CSCI. While the modernisation agenda of the CSCI has clearly forced change and specific instances of deprofessionalisation there is also an element of the inspectors' reactions to changes that are similar to complaints in other bureaucratic professions across the private and public sectors (Bell, et al. 2008), which suggests most bureaucratic change is met with unease by staff.

Consistency at the expense of professional expertise?

Historically social care inspectorates have exhibited huge inconsistency across England (see data synthesis in SR, Chapter 2). In response to this one of the key goals of the Care Standards Act 2000 was to ensure all services were checked against the same standards and were asked to achieve the same quality of care. There is an inevitable tension between 'levelling up' of services nationally to a set of universal standards and the need to take into account local diversity. The director element of the CSCI has invested heavily in training and manuals in an attempt to standardise both the process (methods) of inspection and judgements of outcomes. This high level of standardisation aims to minimise variable judgements and competencies. My interviews with inspectors suggest that this investment has had the desired effect and the inspectors were conscious of ensuring they were being as consistent as possible:

‘... the issue with us now is being consistent, and that’s across England not just in our office... (and) I think that’s right I mean each home service should have to work to the same rules (Inspector CH 3, interview 2)

Inspectors had, in the main, accepted (although not agreed with) the idea that consistency should supersede any calls for leniency or exceptions as the result of local issues. The inspector of CH 3 did offer leniency to the service she was inspecting, but only around the minor issue of allowing them to find a safety certificate, which they had misplaced. She reasoned to me, without prompting, that this is one of the few areas she would be lenient. In contrast the inspector of CH 4 would not allow the manager to retrieve certificates from the Head Office of the parent company. These decisions are marginal judgements, made at the edge of what is prescribed or acceptable. Inevitably these decision will therefore involve some human agency no matter how standardised the process becomes.

Although they accepted the need for consistency there were still tensions in the eyes of all four inspectors between a high level of standardisation and the fact that this was often ill-suited to the complexity of real-life situations. If it is going to be consistent across the board, inspection will inevitably be unreasonable sometimes in the face of unique local conditions. This situation was particularly prevalent in case studies 1 and 3 where the manager / owners felt there was a lack of understanding regarding the financial and organisational constraints of their independent status.

In seeking consistency the CSCI inevitably have to be prescriptive in their judgement guidelines and in their protocols that govern inspectors’ actions and remit. Under previous inspection regimes problem solving occurred at the local level, either by an inspector independently, or a group of inspectors discussing a particular course of action. This ‘street-level bureaucracy’ (Lipskey 1983) was a feature of old local inspection regimes and the inspector of CH 4 looked back on it as being effective, especially in terms of fostering compliance through a sense of partnership and encouragement:

‘You see before we would give them a bit of advice like, it was a more helpful role, and personally I think that was better... er we got them to do more you see’ (Inspector CH 4, interview 1)

Accepting the erosion of local-level autonomy was difficult for all four inspectors, who had all worked in previous local inspection regimes and thought that the flexibility of making local-level judgements was valuable.

This move towards constancy inevitably meant that some of the benefits of local inspection systems were lost, the main one being the ability of the inspector to work constructively with a service locally and being able to use their judgement to give leeway or make allowances in the hope that the service will improve without support. It appears that the main problem for the inspectors was that the CSCI had stopped them from working with the home to build on strengths. Instead it only allowed them limited punitive sanctions with which to force improvement, rather than using the notions of partnership and assistance that they valued as local inspectors.

Director control over judgements: KLORA guidelines

KLORA guidelines have standardised the criteria under which inspectors make their judgements against the NMS. They have made comparing judgements across England more consistent, which is one of the key aims of the regulatory project (CSCI 2009). The NMS have allowed the CSCI to demonstrate improvements in quality across services, as the manager of CH 3 pointed out:

‘The stats will tell you it’s improved things, I mean there are less poor homes now’
(Inspector CH 3)

There is some contention over whether the MNS and KLORA guidelines simply serve to reify the CSCI and inspection by showing improvement against the standards but not necessarily improving care in services. The RM from case study 2 believed that KLORA was helping the CSCI to improve standards on the ground by specifying decision-making about quality levels:

‘Last year it was a bit of a guessing game about what was a level 1, 2 or 3, whereas now we’ve got the rules it’s a bit more consistent across the country’ (RM CH 2)

As I have discussed in previous chapters there was clear discontent with the regulatory process, but these did not completely negate stakeholders views of the benefits, nor the opinion that the principle of inspection is a good one.

However, according to the inspector of CH 2 the level of consistency required had still not quite been achieved, and this accounted from some of the problems and reservations:

‘I think within the Commission we know where we are going, but we’re not quite there, so there are some differences in approach’ (Inspector CH 2)

To inspectors the KLORA represented another standardisation tool (along with the IR) that eroded their autonomy and ability to reflect on quality during inspection. As the inspector of CH explained:

‘...do I find them helpful? I find them restricting and they take away professional judgement... this is shown when the rules conflict with what we think, e.g. some homes I think are good actually by KLORA guidelines only come out as adequate’ (Inspector CH 3)

There were operational problems with KLORA. The inspectors were not totally comfortable with the KLORA guidelines or how to implement them and there were differences in opinion regarding how far they should be followed. The inspector of CH 4 felt she had to follow them to the letter and actually go against her own overall judgement:

‘If we didn’t have KLORA I’d probably have made that section an adequate but given the home an overall judgement of good, but with the current rules making that section adequate will mark the whole home down’ (Inspector CH 4)

The inspector had assessed the evidence and decided that overall the home was good, but there were two maintenance certificates missing which meant the section on Environment (NMS 24 – 30) had to be marked as adequate even though every other section was good, this pulled the overall quality rating down to adequate.

However, elsewhere the KLORA were not followed to the letter. There was an interesting use of informal ratings in Case Study 2. The inspection unit was internally sub-categorising within the level 1 category based on the local knowledge of the inspectors and their managers:

‘I call the less bad ones pinky level 1s’ (RM CH 2)

This demonstrates the use of local flexibility and knowledge to develop a further level of specificity for the homes under their jurisdiction. The RM in Case Study 2 spoke of pressures from the CSCI hierarchy to lower the number of level 1 or ‘poor’ services they have on their books. In response to this pressure the ‘pinky’ homes were those which are close to moving out of the level 1 category, and provide targets for the inspection team to push improvements and lower the number of level 1 services they have.

The negotiation between the prescriptive guidelines laid out by the KLORA and the influence of the inspectors own knowledge and experience was central to the inspection process and implementation of the standards. The tension lies in achieving an acceptable level of consistency while also allowing for some flexibility and giving inspectors the ability to react to the situation:

‘You see I know that I use a lot of my own personal stuff, outside of the standards, whether someone could come in without that and cover everything, I don’t know’
(inspector CH 4)

Balancing judgements between residents views and professional opinion

A frequent dilemma for the inspectors was how to balance the value of service users’ views and opinions about the quality of a service with other evidence. This was particularly difficult if there was a large amount of evidence suggesting a service was performing poorly against KLORA indicators, but residents seemed happy and content with their lives. The issue forms part of a wider debate in social care about the right of professional individuals or organisations, working on behalf of the state, to use objective evidence to overrule the wishes of individuals. The question of balance was superfluous for inspectors if the problem had a direct negative impact on their safety or welfare.

In these instances there was no debate: the judgement of the professional, supported by documented evidence should supersede residents views:

‘I mean sometimes there’s no debate, for example if there is a problem with medication like there was in the inspection you saw’ (Inspector CH 2)

The debate was more subtle in terms of outcomes that determine quality of life. There was a feeling amongst the inspectors that older people have a tendency to ‘accept their lot’ (Inspector CH 1) put up with certain things they do not like because they see no other choice:

‘They often seem prepared to accept things we wouldn’t and I don’t think we should let that happen. It’s a kind of accepting of their lot if you like and we’re here to prevent services taking advantage of that by saying look there are standards you must meet’ (Inspector CH 1)

‘well some service users can be accepting of an environment, they are accepting of a poor home because they feel they have no choice... I think families might choose but choices are taken away from them (*the residents*), it’s a balance between the NMS and speaking to people which forms a picture at the end’ (Inspector CH 4)

This view is supported by my data on residents views of good quality care across the case studies. They were influenced by a social construct that sees ageing as representing decline and decay, both biologically and psychologically, they tended to accept uncritically the ‘culture of care’ within services.

Much focus is now placed on the value of a person’s wellbeing and it is right that they should be able to define this themselves, but if there is evidence that the service is unsafe or exhibiting a poor service then the inspector’s were adamant that they had a duty to protect and prevent residents from accepting poor service because of their outdated conceptualisation of the ageing process.

Validity of standards

Data from my interviews with staff and managers shows that the CSCI had generally done a good job of communicating the purpose of the standards and demonstrating to services that they were justified in the context of better care. It was interesting that past problems and incidents of abuse reported in the media seemed to have considerable impact on their acceptance of the CSCI. This was much more prominent than accepting a system of provision and regulation that has developed through an ideology of new managerialism. Both managers and staff referred to these issues when asked about the validity of the current standards:

‘Well we can’t have it like it used to be can we, when people were getting away with all kinds of horrible abuse and things’ (Staff 1 CH 1, interview 2)

‘... I mean I we wouldn’t want it to be like it was in the 80s with news about abuse all the time... no I think this is a good thing’ (Manager CH 2, interview 2)’

As the inspector of CH 2 explains the CSCI had made an explicit shift direction towards focusing on the service user by demanding an increase in use of their comments in the report:

‘We (*CSCI*) have been told we’re not using enough resident comments in our reports, so now we have to make sure we do more’ (Inspector CH2)

But this was seen as a paradoxical problem, when on one hand CSCI were expecting a more user focused report by including more of their comments, but at the same time creating a barrier to this by requiring a greater audit trail:

‘I don’t think we have enough time to focus on outcomes, we’re assessing data rather than inspecting’ (Inspector CH3)

This finding fits with another criticism of new managerialist service provision that suggests an increase in technicalisation actually prevents achievement of original organisational goals and outcomes (Munro 2004). The inspectors questioned the validity of

scoring and felt that sometimes the overall quality score determined by the NMS was unfair and went against the overall picture as judged by the inspector.

The shift away from support: A top-down policy

The shift from consultation and advice being part of the regulatory process, at least informally, to inspectors no longer offering any assistance has been a stark and sudden and according to the RM in Case Study 2 and this has hit some providers quite hard:

‘Gone are the times when we have cosy little chats with providers, give them friendly advice, you know. We don’t do that anymore, I mean you may get them... I know many providers who find it difficult now I mean before we used to get them in at registration, discuss their plans, talk it through, there’s none of that anymore. Now they need to know what the law is and get on with it’ (RM CH 2)

The inspectors’ discussion of interaction confirmed data from my field log which shows that despite efforts from managers to engage inspectors in informal ‘chats’ concerning strategies to address criticism, inspectors were very careful to avoid getting into lengthy conversations on these topics. Instead they referred managers to the website run by the GSCC. The inspector of CH 1 explicitly told the manager it was his job as manager to have the knowledge to manage the service successful and be able to cope with the technical requirements of the audit trail.

Their comments to service personnel during the visit contradicted what all four managers said in their interviews after the inspection, in which they were all sympathetic with the managers’ predicament. Sympathy seemed particularly strong from the inspectors of the two independently run services, because of the financial constraints smaller providers faced.

The inspectors exhibited a clear distinction between their beliefs and actions during the inspections. They were constrained by organisational directive to follow procedure but they felt it reduced their power to induce change:

‘I think our authority is lessening, especially in terms of what I can put on as requirements, they have to be considered more now, and they have to be legally enforceable. I guess before we had more flexibility about what we could put in as a requirement’ (Inspector CH 4)

THE DETECTOR

The detector role involves a complex system of checks that include analysis of documents and data, site visits and increasingly self assessment. Inspectors provide the detection role in the regulatory process, using a variety of methods to test that the systems of delivery are in place to produce a high quality service. The focus of inspection and methods of detection are described in Chapter 4 so will not be elaborated on here. This section uses data from my field diary and interviews with all stakeholders to examine the qualities required to be a good inspector.

Inspector qualities

As described in Chapter 4 the system of inspection involves a range of tools and methods of detection, and the process can be broken into two main phases:

1. Analysis of documents and information prior to the inspection.
2. The site visit.

The benefits of inspection are dependent on the ability of inspectors to operationalise the inspection framework and use their own experience and judgement to apply the standards effectively:

‘Skilled and credible inspectors are the single most important feature of a successful inspection service... credibility will derive from the inspectors’ experience and knowledge, as well as the way that they conduct themselves in doing their job’ (Audit Commission 2000: 9)

The ‘director’, in this case CSCI, can develop a well regarded framework but it will be inconsequential, if it is not applied properly. In order to build a picture of a good quality inspector I asked all stakeholders for their opinions and used these to supplement my

observations. Data from the case study interviews suggests the following qualities are important:

1. Experience / Skills / background
2. Understanding of home (but not too much to induce regulatory capture)
3. Fairness
4. Friendliness
5. Respect – the ability to both able command and give respect

The five qualities listed above together provide the tacit knowledge that inspectors' themselves so valued. Analysis of data concerning the qualities required to be a good inspector led me to consider the types of knowledge required to make inspection decisions and judgements. This discussion is interwoven to the following analysis of the facets of a good inspector.

Experience and skills: Adding-value

A key skill described by all stakeholders was that the inspector must use their experience and knowledge to 'add value' to local services:

'well they should be making it better for us' (Resident 2 CH 4, interview 1)

In this respect they must be able to spot errors, instances of poor practice or areas where practice is acceptable but could be improved. To residents and relatives the key skills important for an inspector were the experience and knowledge to be able to judge a home. Residents wanted inspectors who were experts in the field of social care and had sufficient experience and skills to spot deficiencies and assist in making corrections. Residents did not make the distinction between inspection and support, in the sense that they thought part of the role of an inspector was to help the home correct any faults they found.

Understanding of home

Both inspectors and managers thought that some familiarity with the service was beneficial. In particular managers thought that inspection was more effective if they knew the inspector and how they worked. This meant they had to spend less time with the

inspector and could get on with their job, lessening the impact. Staff also thought that having an inspector who they knew was mutually beneficial in the sense that they felt less intimidated and the inspector was therefore likely to get a more honest answer and see the normal workings of the home, less affected by a nervous staff.

During my data collection the CSCI was in the process of shifting from a case load system (where inspectors were responsible for administrating and inspecting a certain number of homes) to a key worker system (where inspectors would be responsible for the administration of the home but would not necessarily inspect the home). The inspectors were afraid this would mean they will be less familiar with the services for which they are responsible, as in theory they could never have actually visited the service:

‘Well I just worry that I could get services to go and inspect for which I have no prior knowledge and I could end up looking after ones that I’ve never been to, I don’t like that idea’ (Inspector CH 4, interview 1)

As this system had not been put into action during my data collection further work with what has now become the Care Quality Commission (CQC) would be required to see if the inspector fears have been realised in practice.

For the inspectors the main benefit of familiarity with the service was the cumulative knowledge they developed. They felt their working knowledge was far better if they had the experience of visiting the service on prior occasions, rather than simply using previous inspectors notes and self-assessment data as was being proposed in IBL.

Residents’ and staffs’ comments that suggested inspectors should ‘get a feel’ for the home raised questions about the types of knowledge required to inspection. I agree with work of Schön (1983) on reflecting *in* practice that a key value of inspection lies in an inspector’s ability to use their tacit understanding of the individual home, the nature and aims of social care and the goals of the inspectorate. This puts them in a unique place to make judgements about quality of service provision. When this is marginalised both inspectors and the services being inspected lose a valuable resource of effecting change.

Fairness

Stakeholder opinion of fairness varied depending on their relationship with the inspection process, which in turn was shaped by their prior knowledge of regulation. Residents who across the case studies admitted very little prior knowledge of inspection saw fairness as meaning the inspector gets a true picture of the service through residents' experiences:

'I think they should speak to us to find out about the place. We know best as it's here for us' (Resident 1 CH 1, interview 1)

Relatives framed fairness in a similar way focusing on the outcomes rather than the processes required to achieve them. There was also a feeling amongst relatives across the case studies that inspection should focus more on the bigger outcomes and less on the detail. One relative in CH 2, who was visiting the home on the day of the inspection, thought the inspector was 'nit-picking' and 'missing the bigger picture' in favour of small issues that in his opinion, while necessary to point out, should not effect the overall tone of the report, or judgement:

'I think they're a bit unfair when they nit-pick, for example they should be concentrating on the atmosphere of the place, rather than saying mum hasn't got her footpads (on her wheelchair) on today' (Relative 1 CH 2, interview 2)

These opinions demonstrate that relatives' concerns focused primarily on wider issues such as happiness and the atmosphere of the home. These types of service qualities cannot be measured using indicators and standardised judgements such as KLORA. They require a different type of knowledge based on reflection, experience and a tacit understanding of service provision (both in general and specific to the service) – qualities inspectors have. Relatives failed to sometimes see process issues, which if neglected could lead on to bigger outcomes failures, as important.

When managers spoke about fairness they really meant empathy, for example the manager of CH 1 was completely preoccupied with the home's finances and the impact this had on his ability to develop the quality of service. He wanted the inspector to empathise with this

issue and in turn give the home leeway on some of the criticisms found, especially those, like training, that involved a large capital outlay:

‘... tell me how I’m supposed to afford to spend that (*to rectify all of the requirements*) Matthew? We charge over two hundred quid less than some places round here, how can they expect me to compete with those places’ (Manager CH 1, interview 2)

I have already discussed the inspectors’ sympathy for the amount of compliance required to meet all of the NMS. However, there was a limit and particularly in the case of CH 1, which had made little progress over the previous CSCI inspection, the inspector was losing any sympathy:

‘I know it can be tough sometimes for the smaller homes but I think it’s excuses to be honest - they seem more concerned with the environment and not the care, (*the manager*) needs to re think his priorities’ (Inspector CH 1)

Friendliness and respect

As discussed in Chapter 4 inspectors voiced caution about their relationship with the home manager. There was a conscious effort to remain professional but at the same time friendly. The manager of CH 4 pointed out that inspectors tended to get the best results when the service feels as though they are being constructive and helpful, building on the strengths of services, rather than being authoritarian and simply criticising:

‘I think when the inspector says nice things or talks about where we can improve rather than just what’s wrong, then that’s when I think inspection is best’ (Manager CH 4, interview 2)

The managers advocated a friendly approach, they felt they were more likely to action the changes if they respected the advice and judgement of the inspector, rather than feared punishment of the organisation:

‘I mean the last inspector was terrible in my opinion he just came in and said what’s what. At least (*inspector*) comes in and tries to be a bit more helpful’

Inspector Inconsistency

Despite the centralisation of inspection since the Care Standards Act 2000 and the introduction of NMS and KLORA guidelines to standardise inspectors’ judgements, managers still complained about instances of inconsistency. This inconsistency understandably led to frustrations for managers, as the Line Manager of CH 2 pointed out:

‘well, a new inspector has come in to one of our other homes I run and for years another inspector has said the toilet situation was ok, because the staff were taking residents to another set of toilets further from their rooms, but a new inspector has come in and said it’s not ok... They’ve shifted things seemingly just because a new inspector has come in’ (Line Manager CH 2, interview 3)

All four managers talked about inspector inconsistency as a key frustration. While others could not cite specific examples the Line Manager of CH 2 and the manager of CH 4, who both liaise with other care homes, saw inconsistencies between inspectors both across inspection offices (in the case of CH 4, who felt her service was subject to slightly different inspections than other homes in the company inspected by inspectors from other CSCI offices), and within the same inspection office but by different inspectors (in the case of CH 2). Both managers expressed exasperation at the differences in expectations across services, and thought it was inspector inconsistency that was causing the problem:

‘See I’ve got one home where the inspector isn’t happy with the care plans, yet every other home seems to get an ok, so I’m in the process of redesigning them all to fit what this inspector wants... You see I can’t have different plans across my homes, so I’m changing for one inspector’ (Line Manager CH 2, interview 2)

‘I’m in (*region*) here and the other homes are in (*region*) and we have different inspectors and my inspector might say ‘that’s acceptable’ but an inspector in (*region*) will say ‘no it’s not’. So we’re looking at our care plans and trying to collaborate’ (Manager CH 4, interview 2)

It is clear that no matter how prescriptive judgement guidelines like KLORA are there is always going to be some scope for interpretation, which inevitably leads to different decisions. There is a distinction between decision-making at the margins of the regulations and clearly breaking the rules. As professionals inspectors are also going to make some decisions which bend the guidelines, as in the actions of the inspector of CH 3 who gave leeway for a certificate to be faxed to the inspection office two days after the inspection.

Difficulty for inspector to get a true picture of the service

As described in Chapter 4 inspection only lasts for the equivalent of two working days, one to prepare and analyse pre-inspection data and the second to conduct the site visit. This means inspection only offers a snapshot of the service in which the inspector only has a limited time to construct a true picture of the service. The Line Manager of CH 2 highlighted this issue with reference to the possibility of one vocal resident skewing the overall picture:

‘I mean it’s obviously difficult to get a good understanding from such a snapshot because it’s difficult to get the balance correct... the last report seemed like in each section he had only spoken to one man and his views became the views of the whole population’ (Line Manager CH 2, interview 1)

The issue of the ‘snapshot’ nature of inspection was also a cause of frustration to the inspectors, who despite accepting that the audit paperwork was necessary felt it led to further marginalisation of the views of service users:

‘I don’t think we have enough time to focus on outcomes, we’re assessing data rather than inspecting and we only have chance to get limited number of service user views’ (Inspector CH 3)

The issue also highlights the paradoxical nature of the focus of inspection:

‘We (CSCI) have been told we’re not using enough resident comments in our reports, so now we have to make sure we do more’

MN: 'How does this sit with the time pressures?'

'Well I guess we have to use more of what we hear, and try to speak to more residents, but I'm not sure how we are going to do that' (Inspector CH2).

The CSCI is professing to do one thing, but the system of inspection that is in place forces inspectors to marginalise the focus on user outcomes the CSCI claim to be so important.

Working with Councils: Regulatory fragmentation

The issue of multiple inspection visits was mentioned by almost all staff and managers in their interviews. Although the CSCI is the national regulator regulation is a complex patchwork of different bodies, and this leads to duplication and an increased burden on services. As the manager of CH 4 explained:

'I can't see why there can't be more cooperation, I mean we had a meeting yesterday about codes of conduct and you've got one from the CSCI that you work to, one from the council, and you've also got the general council structure and it's all the same thing basically... why they can't all incorporate I don't know' (Manager CH 4, interview 2)

An important effect of the duplication was that it led to confusion and sometimes conflict between requirements:

'I've had the CSCI tell me to move the toilet so it is closer to more residents, but the councils say it is fine... oh it's very frustrating' (Line Manager CH 2, interview 3)

Although the main duplication came from overlap between the CSCI and local councils; managers also spoke of visits from fire inspectors, building inspectors and inspectors of the call alarm system.

The inspectors felt that the lack of communication between themselves and councils was problematic and weakened the process of regulation. As the above quote shows managers were sometimes left confused about whom to follow.

Enforcement was also a problem because in light of the slowness of its own enforcement procedure the CSCI was increasingly relying on councils to enforce improvement through threats to stop contracting with services, and making quality assurance part of contractual agreements. However, the inspectors across the four case studies all felt direct communication with council quality assurance teams was poor:

‘... er I mean I guess in theory we work together but I very rarely hear from anyone in the council... I mean we get notified of complaints but I never really speak to anyone’ (Inspector CH 4)

THE EFFECTOR: INDUCING CHANGE

A successful inspection system needs an effective way of changing the behaviour of service providers and improving performance. Without this successful director and detector systems will be of little value. The regulator needs to either convince providers to pursue the actions and objectives they prescribe or provide real and feared punitive measures that will force providers to comply. The question over what constitutes a strong effector is debatable and there appears to be some tensions within the CSCI’s approach to effecting change.

Boyne et al (2001) identify two main ways of effecting change, the first of which I have split into two separate mechanisms:

1. Advice
 - a. Informal advice
 - b. Formal reports by inspectors that include requirements which the home *must* act upon and recommendations to improve practice but which are not legally binding.
2. The powers available to central government that may be triggered by the findings of the inspectorate.

I would also add a third mechanism to Boyne et al's (2001) methods:

3. Standard setting and promoting cultural change

Advice

Analysis of my observations during the inspections and interviews with stakeholders shows that advice was broken down into two categories: Informal and formal.

Informal

The CSCI has all but eliminated the use of informal advice by inspectors and as described in Chapter 4 this directive was adhered to in all four of my case studies and street-level support has been all but eliminated. What was evident from observation of the case studies was that despite the tough stance from the CSCI the inspectors instinctively veered towards persuasion, helping services to comply with regulations rather than punishing them. This finding was similar to that of Day and Klein (1997) who found that in the face of a tough stance of the regulatory body, the inspectors used a more understanding approach aimed at raising standards and fostering compliance. This also fits with Harlow's (2004) argument that social workers have a tendency towards social justice and caring that leads them into the profession, but then often find that the system in place restricts this tendency. This was the case with the inspections I observed where the organisations tough regulatory stance with a policing element was complemented by inspectors trying to encourage compliance through emphasising strengths and the merit of improvement, but without going as far as giving direct advice.

Formal

As we have seen in previous chapters the inspectors were restricted in the amount of assistance they could give the services. They were restricted to pointing managers in the direction of the GSCC, Skills for Care and other support organisations for help and the limited 'catalytic feedback' (Braithwaite et al 2007) they could give in the report. However, this feedback in the report is indirect in the sense that the managers have to dissect the report and extract constructive feedback from the text. Recommendations do provide some assistance in the sense that they often flag small problems that, if acted upon, can cumulatively improve practice, but this type of advice was less valued by managers.

Punitive powers

The main method of effecting change used by the CSCI is to make requirements in the report and then follow these up to check if the changes have been made within an agreed timescale. The requirements follow a punitive course and are ultimately underpinned by the power of government to close a service if it is performing poorly.

Inefficiency of ultimate sanction

Ayres and Braithwaite (1992) argue that in order for regulation to be effective it must be underpinned by the ‘ultimate sanction’, which in the case of the CSCI is the ability to close a home down:

‘Regulatory agencies will be able to speak more softly when they are perceived as carrying big sticks’ (Ayres and Braithwaite 1992: 6).

Data from the case studies shows that the possibility of the CSCI actually taking punitive measures except where safety is compromised is very low, and as such shows the deterrent aspect of regulation is often ignored. Between the four case studies there were nine previous requirements (i.e. issues which legally must be addressed) uncompleted beyond the initial timescales agreed. Four of these the timescales set out in the reports had been ignored on more than one previous occasion. This gives two key insights into the workings of the CSCI: first, there is a lack of effective punitive power and secondly, in practice inspectors have to work hard in the face of limited options to coerce services into requirements, because the threat of force is somewhat hollow.

The evidence regarding lack of punitive power was highlighted in my conversations with the RM of CH 2. She talked about the lengthy cumbersome process of closing a service:

‘It’s a slowish process as you have to first send out a letter, then they have 28 days to write back, and then their case has to be heard by a director, that director has to then write a notice through the commission (*CSCI*) to the home’ (RM CH 2)

Inspectors of the other three case studies spoke of frustration at the paucity of action in the homes and highlighted the contradiction between the CSCI aims and the difficulty in pursuing punitive action, which can take over a year. As the inspector of CH 1 commented, they frequently felt ineffective:

‘... it does get frustrating though when you feel like you’re just banging your head against a wall ‘cos nothing happens’ (Inspector CH 1)

Data from earlier studies on nursing homes also shows how punitive sanctions have historically been slow to deliver. For example Day and Klein’s (1987) study on nursing homes in the UK shows only six were deregistered in a two year period in the mid-1980s.

Discretionary sanctions

In an acknowledgement of the problems with the punitive powers at the disposal of the CSCI the RM of CH 2 talked about using informal agreements with councils to stop them placing any more council funded residents in a problem service and even informal agreements with services themselves, who agreed to stop moving residents in until the serious concerns of the CSCI had been addressed:

‘I have on occasion just come to an agreement with a provider not to move people in, erm... it’s much better than going down the legal track’ (RM CH 2)

This stance led to instances where judgement could sometimes override the prescriptions of the standards. In these instances the inspectors were instructed to gage their overall impression of the service, and if that was good, but there was one area where there were severe shortcomings they would push up the overall score but follow the issue up using an intensive course of random inspections to force improvement:

‘... normally it would be a level 1 because of the immediate requirement, but the general the picture is good and it is not a level 1, but they have a major shortfall in one major area, so I will make it an adequate and then follow it up’ (RM, CH 2)

These instances of upgrading prior to improvement by the service reflect a national pressure on the regional inspection units to push as many services out of the level 1 (poor) category and show the lengths to which inspectors and their managers will go to achieve this progress. The inspector was clear to point out that he would only do this if all other areas of the inspection were above level 1 and he could see a real commitment to quickly improve the problem area from the service.

This was achieved by discounting the score for the area that would only score 1, marking up the home based on the other scores and then using random visits to ensure the service had corrected the problem. The RM and Inspector of in case study 2 did stress that they would only do this- if the home was getting higher scores for most of the other standards and it was only problems with one or two Key Standards that were causing the home to be scored at level 1.

This action resulted from the pressure the CSCI to push as many level 1s up into the next bracket during the 2006/2007 year that I followed. This impetus appears to stem partly from financial pressures within the CSCI:

‘The number of randoms are supposed to be going down this year because we’re looking at head counts and we just wouldn’t have the numbers to go around, to do all the ones we did last year... I guess it’s all about modernising regulation’ (RM CH 2)

With year on year budgetary cut backs the CSCI can no longer afford to carry out the number of inspections it could in previous years. This means that although there is obvious altruistic, ‘quality of service’ reasons for forcing improvement in the services, there are also egoistic, self-preserving reasons: the higher the CSCI rating the less inspections the CSCI needs to conduct each year. The CSCI is being forced to scale back its operations, while still maintaining ensuring services maintain standards. The RM of CH 2 believed that this led to different local level solutions to the drive to decrease inspections, which caused inconsistency:

‘yeah... what percentage of Eastern region homes might be level 1, say 20 % I can’t remember, I’ve only got 2 %, so yeah. There cannot be services that are so much better in one part of the country, not that big a difference’ (RM CH 2)

The fact that inspectors are using informal persuasion demonstrates both the impotency of CSCI punitive power and the creative ways inspectors are using their professional experience to compensate for organisational deficiencies. Once again discretion was used to create effective local level solutions.

The contrast in reaction to requirements between case study 2 and the other three shows the inspection office in case study 2 had managed to develop a more effective local level system of compliance than others. They achieved this through making the threat real by instigating the most enforcement actions in their region and showing services that they are prepared to take enforcement action where necessary. This organisational ethos influenced the way in which the inspectors approached inspection and they were confident that their requirements would be supported by enforcement action if not complied.

Services realise they can get away without acting on requirements and this jeopardises the efficacy of the inspection process. The CSCI cannot claim to be driving up standards and punishing poor providers if its actions are simply being ignored.

Cutting back on issuing requirements and regulations

The issuing of requirements and recommendations was handled differently across the case studies in terms of enforcing the timescales in which they had to be carried out. Inspectors were all aware that requirements were only supposed to be issued if they were prepared to take punitive action against the service. The regional office responsible for inspecting CH 2 had taken the tough line of the CSCI in ensuring that timescales were met while other offices were clearly letting services flout regulations:

‘We don’t make requirements anymore unless we’re prepared to go further, so if it’s not done next time we take enforcement action... we’ve done more enforcement action than any other office (*in their region*)’ (RM CH 2)

‘we’ve lost the smallest number of level 1s in the region, so we are forcing improvement... we’ve been really focusing on the level 1s’ (RM CH 2)

Standard setting and promoting cultural change

The CSCI has an educational and policy-guiding role, and in this sense it aims to shape service provision. Their role in educating services comes through inspection but also the standards themselves.

However, as we have seen the nature and complexity of both the process of inspection and complying with the NMS has hindered progress of services in this case study. I have argued that a stifling of progress results from the conceptualisation of service provision as a set of operations that can be reduced to measurement by indicators. By adopting this approach the CSCI emphasises its function as a service-shaper, underpinned by the premise that it sets standards and managers are expected to have the skills to analyse the report, determine the need for change and then effect that change, all while continuing to run the service. This role and its effects in terms of the marginalisation and slow progress of some services were increasing as the CSCI shifted further to a standard prescribing approach through the implementation of prescribed judgements, rather than supportive inspection based on the reflexive judgements of professional inspectors.

CONCLUSION

I have analysed the data on good quality inspection through three-part framework: *Director, Detector and Effector*.

The director element focuses on the leadership and managerial structure of the CSCI. Data from interviews and my field log suggested that inspection was partly self-serving in terms of collecting data that justified its own role. For example, the inspectors are forced by procedure to spend the majority of time during the site visit inspecting paperwork even though the CSCI has asked for a greater focus in the reports on service user outcomes and a documentation of their comments to evidence this focus.

Consistency has taken primacy over inspectors' professional expertise in the *modus operandi* of the CSCI. The introduction of the KLORA through the modernisation project of IBL has increased the marginalisation of inspectors' autonomy. However, as others have shown elsewhere within the bureau-professions (see Evans and Harris 2004), a tightening of standards led to discretion, both from inspectors themselves and managers at the local level. The RM in case study 3 had begun to categorise 'poor' homes as either red – i.e. those with multiple or fundamental failings and 'pink' – i.e. those which are nearly adequate and often only 'poor' because the increasing tightening of standards has shifted the line to the extent that they fall back into the 'poor' category.

Stakeholders identified five key qualities that inspectors need to carry out their *Detector* work:

1. Experience / Skills / background
2. Understanding of home (but not too much to induce regulatory capture)
3. Fairness
4. Friendliness
5. Respect – the ability to both able command and give respect

These qualities suggested implicitly that most of the stakeholders believe that inspection is about more than just an inventory of standards but also requires a focus on qualities that cannot be easily reduced to standard judgements, such as the atmosphere of a service. This requires a different type of knowledge that comes from inspectors experience and tacit understanding of the care process.

Analysis in previous chapters has shown the limited scope inspectors now have to provide advice or work in partnership with services. The main method of inducing change was through the threat of punitive sanctions, but these were slow to implement and not often used by inspectors. Instead services have got savvy to the lack of punitive options available to inspectors so changes are often slow to materialise. In conjunction with the constraint on any form of partnership working with services to improve, inspectors were frustrated that progress was often slow for 'poor' services. However, at a regional level some CSCI offices had developed discretionary solutions to this problem.

The CSCI appears to predominantly rely on its role as a leading voice in social care and position as standard bearers of purveying notions of good quality care. This narrows the role of the CSCI and presents it as auditor in the neo-liberal, new managerialist sense of checking on standards but devolving responsibility for improvement to managers and service providers. This is clearly the trajectory of the CSCI but is leading to discontent within the workforce and marginalisation of inspectors. It is also clearly not forcing improvement because services require support. Inspection appears to have taken a retrospective step when considered through the conceptual lens upon which social care provision was built: social justice.

CHAPTER 8: CONCLUSIONS AND DISCUSSION

INTRODUCTION

In the final chapter of this thesis I draw together the findings from the systematic review in Chapter 3 and the thematic analysis presented in Chapters 4 – 7. The findings focus on a series of aims that together build a picture of inspection in an attempt to examine how it serves to influence service quality, as well as touching on the question of ‘what is good quality care?’ In conducting this research I had a unique insight into inspection and the decision-making process involved, which other researchers have often had trouble gaining access to (see Travers 2007).

At the beginning of the study questions about effectiveness were very prominent. This led me to conduct a systematic review to determine whether there had been any previous research into the effectiveness of inspection on residential care for older people.

Having found a dearth of evidence of both gold standard effectiveness data and data on impact I focused my case studies on the processes and consequences of inspection and discussed any pitfalls that existed. In this way the thematic analysis has given some answers to the remaining aims of the study; namely, to add to the evidence on what makes for good residential care inspection and the most effective ways of maximizing quality of older peoples’ residential care. Thematic analysis has focused on issues such as the process and impact of inspection; looking at ‘how’ an inspection is carried out, asking the relevant stakeholders about their experiences of inspection and looking at the impact over time. In writing about these themes I have been pursuing the most general aim of the study, namely to understand more about the dynamics of the relationships between inspection and good quality care.

In the final part of this chapter I use my findings to offer guidance to the new inspection body that replaced the CSCI in April 2009, the Care Quality Commission (CQC). The CQC was enacted under the Care Standards Act 2008 and given new powers of enforcement. However, it has continued with the CSCI inspection regime during 2009 – 2010 but plans to continue the evolution began by the CSCI and change its methodology in

2010 – 2011.

NO RESEARCH ON EFFECTIVENESS

My systematic review showed there have been no studies into the effectiveness of inspection on older peoples' social care and very little research into its impact. The lack of research reflects the fact that it is very difficult to conduct any kind of control-based study of services that are universally regulated: it would be both unethical and illegal to select a control group of residential care homes that would not receive an inspection.

Therefore the debate has not been well informed through empirical evidence and robust academic research into the methods, costs and impacts of regulation in social care (Sutherland and Leatherman 2006). Since its inception in 2004 the only real evaluation of its function has been by the CSCI itself. There have been studies into the regulation in many other settings from financial institutions and markets (see for example Grouta and Zalewska 2006), to environmental regulation (Gunningham, et al. 1998) and healthcare (Walshe and Shortell 2004). There is also a considerable body of literature on the theory and practice of regulation, some of which draws on comparative research to offer theoretical tools and frameworks (see Braithwaite, et al. 2007). Examining regulation from an economic perspective Boyne and Day (2002) developed a framework that breaks regulation down into costs and benefits, with benefits including improvement of service standards, providing a safety-net and an assurance of minimum standards. However, as the systematic review in this study demonstrates, this framework has never been used to determine a cost-effectiveness calculation of inspection.

THE PROCESS OF INSPECTION

The CSCI: practising what it preaches?

It is helpful to draw out the policy aims of inspection by the CSCI:

- *Government-driven*: although I argue the CSCI has policy influence through the administrators' prerogative, it is primarily government driven.
- Provide a publicly available *quality rating* for each service (not yet 'live' during my data collection, but was very soon after).
- Increase *accountability* and *transparency* through making findings publicly available.

- Delivering *better management*. The CSCI inspection focused on ensuring managers were responsible for delivering good quality services through an emphasis on training and skills.
- *Standardising good practice*. The NMS provide national, standardised guidelines on practice.
- Promote *needs-led, person-focused services*.

The principle of government led inspection was supported by most stakeholders and even though there were many criticisms of its function there was almost unanimous agreement amongst the interviewees of the principle of inspection. They also broadly praised the consistency of standards and the inspection process across England. There was criticism that this standardisation was too pervasive and frequently enforced at the expense of local-level decision-making. Managers felt that inspectors should have discretionary control over issues in which there were clear local-level influences over areas of practice. Inspectors were also of the opinion that if local-level contexts meant a particular service's adherence to a National Minimum Standard (NMS) would have had a negative impact it should be possible to 'trouble shoot' an appropriate solution.

CSCI as a priority setter not a motivator

The data in this thesis show that, although they might not agree with all of the NMS, the stakeholders interviewed all agreed that the CSCI had set a clearly defined set of indicators. When talking about the quality of health care provided in general care practices Rhydderch, Elwyn et al. (2004) claim that:

'Indicators should provide meaningful information which makes it possible to set priorities. Finally the indicators should motivate practices to induce change' (Rhydderch, Elwyn et al. 2004: 214).

The stakeholders agreed that the NMS indicators make it possible to set *priorities* to comply with the regulatory agent. The list of requirements at the back of the report clearly sets out the problems and gives timescales, which should be agreed with the service manager. However, the current inspection process fails to successfully *motivate* change, certainly for homes that are performing poorly. Two homes (CH 1 and 3) in this study failed to make any significant improvements on the requirements issued by inspectors.

Managers and staff in these services were aware of what they had to do to comply with the NMS but did not carry these changes out. This was because although inspection clearly tells services *what* changes are required it provides only distant reasons *why* the service should make changes and no assistance as to *how* the service should achieve them.

This represents a two-fold problem. First, the rationale for the CSCI's vision of quality care and good practice is very distant from service providers. Without proactive searching and synthesising of research evidence and policy arguments by managers the arguments for user-focused, personalised services failed to reach the target audience. This was clearly the case in the two independently owned services that had no support or extra capacity to actively engage with the data and policy. Secondly, if managers found it difficult to understand why they needed to change, they certainly did not have the resources to know how to make changes.

The biggest barrier to change appeared to be motivation, with managers either not believing they needed to change and simply ignoring the requirements or finding other excuses to justify their inaction. With no clear leadership for change this lack of motivation was often spread to staff, and indeed in the case of CH 1 there was no binding mechanism so the staff felt marginalised by the manager and were not prepared to work harder, or stay behind after their shift to complete the necessary paperwork (logs and care plans).

In organisational literature social worlds theory suggests that change emerges as a function of negotiation and renegotiation between two or more social worlds (Tovey and Adams 2001). The theory emphasises the importance of considering who is using indicators and for what purpose. In the inspections I observed there was a clear tension between the practices and activities required by CSCI to meet their quality improvement targets and practices and activities that services believe lead to improvement for residents. The manager of CH 1 summed up this feeling:

‘You see they want me to do things that residents are complaining about... now if (*the inspector*) comes back and there are the same complaints then I'm going to tell him and showing that what he wants is having a detrimental effect on my residents’
(Manager CH 1, interview 2)

This tension was also apparent in CH 4 where residents wanted to prop their doors open because they liked to ‘see the world go by’ (Resident 2 CH 2, interview 2), but the regulations would not let them do this. The service could put in specialist equipment in the form of doors that automatically close in the event of fire, but these were expensive, as the manager explained:

‘See the doors issue is now a big one... we’re having to tell the residents that they must keep their bedroom doors closed, and some of them, understandably hate that. Now, I know we can get those automatic things in, but they cost a lot... er, we’ve even talked about staff ensuring doors are closed in the case of an emergency, but it’s not allowed... and the residents hate it’ (Manager CH 2, interview 2).

The complex relationship between inspectors (detector) and the CSCI (director)

As I have discussed in the findings chapters there is a tension between the prescriptive guidelines developed by the ‘director’ element of the CSCI and the implementation of judgement by inspectors. Inspectors in the case studies were increasingly demoralised and unhappy in their role; one inspector (of CH 1) even threatened to leave the profession if changes continued. Managers, staff and inspectors all thought their ability to induce change and improvements had been diminished by increasing perspiration and restriction which they felt influenced the lack of change over the case study period. This phenomenon is not unique to inspectors in this study, other studies of different professions have shown that frustration at perceived professional marginalisation is a frequent complaint of staff within the bureau professions and represents an ongoing tension within services (see for example Bell, et al. 2008).

This distinction was not clear-cut; the use of reflective judgement had not been wholly eliminated. Inspectors in the study tried to moderate the punitive approach of the CSCI by using judgement and discretion where possible. As a plethora of sociology literature argues even the most rigid scientific experiments still rely on argument and interpretation of results (see for example Latour and Woolgar 1986). No matter how prescriptive guidelines become there is still a need for professional judgement in implementing the protocol. A fact demonstrated by specific instances (for example the leeway the inspector of CH 3

allowed for faxing of a fire certificate) and during the process of inspection where inspectors changed the IR to suit their own preferences.

My data is consistent with the conclusion of Evans and Harris (2004), who when talking about a different bureau-profession argued that the distinction between judgement and standardised processes are not clear-cut:

‘...existence of rules is not inevitably the death-knell of discretion. Rather, by creating rules organizations create discretion’ (Evans and Harris, 2004: 883).

In response to tightening prescription over judgement inspectors muddled through, made do, and subtly recreated the objectives of the system. This in turn provided them with continuing scope for discretion. The result of this is that the application of inspection has become removed from the intentions of the developers within the CSCI.

THE IMPACT OF INSPECTION

A lack of direct impact on residents

Inspection had very little direct influence over residents in my study, in relation to:

- the process of inspection,
- direct changes it induced, or
- increased awareness of CSCI information.

CSCI data shows that residents received indirect benefit from regulation in the form of year-on-year rising standards across the country (CSCI 2007a). However, data from this research shows improvement against the CSCI’s criteria does not necessarily match residents’ expectations and certainly failed to have any influence on these expectations, which were markedly different to the prevailing policy and research opinion.

A synthesis of the findings chapters suggests that managers still feel that service users do not want to be ‘burdened’ with details of their care and that the concept of empowerment has not permeated into practice. This finding reminded me of work on medication management in a mental health setting (Cushing and Metcalfe 2007). All four service

settings offered mechanisms of collaboration that were at best tokenistic and rooted in notions of compliance with institutional routine rather than concordance between residents and the service about provision. This was worst in CH 1 and 3, but also apparent in CH 2 and 4.

Empowerment was challenging for services in terms of knowledge, skills and resources. Thus paternalistic notions formed a 'culture of ageism' that purveyed service provision. Ageism is manifest where powerlessness and dependence is engendered. Although residents views were not treated with suspicion or marginalized completely, my data suggests that residents were still treated on the basis of a negative social construction of ageing (Wilken 1990). Paternalism spread to routines and my interviews and observations suggest that all four homes reflected elements of Goffman's 'Total Institution' (Goffman 1991).

Impact on services

Across the case studies, services had managed to act on thirteen of the twenty-four requirements and simple analysis of the three previous NMS scores for each service in Chapter 4 (see Tables 9, 11, 13 and 15) shows that, although not at the pace the CSCI would have liked, all four services had made some progress against the NMS. All had developed some system of individualised care planning and accountability, even if it did not meet the standards of the CSCI.

CH 1 and CH 3 had been rated as 'poor' since the CSCI's inception, but have still shown improvement in some areas. The inspectors admitted they were providing a better level of care now than they were at the date of the first CSCI inspection. The reason they were still rated as 'poor' or 'adequate' was that they had been unable to keep up with the pace of changing expectations, or 'goal post shifting' that occurred as the regulator developed its methodology. The failings of the 'poor' homes in the case studies were a result of not quite meeting standards, but it was acknowledged that the basic infrastructure was in place.

In their response to the findings in the reports, service managers universally placed the majority of their focus on the requirements issued in the report. These were seen as a set of

tangible errors with which to both interpret the overall outcome of the report (based on the number and perceived severity) and, as discussed earlier, set priorities.

Eleven of the twenty-four requirements issued across the four services had not been 'actioned' by the end of the case studies. CH 2 and 4 were, on the surface, by far the most compliant services; both acted on all but one of their requirements. In comparison CH 1 and 3 performed poorly. However, it became apparent that a distinction between compliance rates was simplistic and more detailed analysis suggested that the amount of time required and complexity of the change required were better indicators of compliance.

The slow progress related to the format of reports and the fact that managers follow a to-do list of requirements rather than critically analyse the whole report. The technology driven scope and format of the report influences this and shows that by focusing on specific indicators the report is in fact potentially constraining improvement. It guides managers towards a linear task of requirements, which results in stepwise improvement rather than focusing on the wider whole picture of service and addressing fundamental issues at a strategic level. This can be seen in the context of wider changes in social services from knowledge as being 'social' and by implication more holistic to being 'informational' with providers being guided from point-to-point (Parton 2008).

Potential compliance is also influenced by interaction between structure and agency within the service. Other studies (see Newman, Glendinning et al 2008) have shown that a service manager's capacity for change has a significant impact on improvement potential. The managers' capacity to change was influenced by:

- disagreement with the inspector and the need for change,
- a lack of knowledge of how to make changes.

My findings showed that a lack of capacity to change reproduced a culture of non-compliant care within the service that guided the actions of staff and also, as I have shown, influences the expectations of residents. This manifests in a lack of empowerment for residents and routinisation that exhibited similarities to Goffman's concept of the 'Total Institution' (Goffman 1991). The data paints a picture of services that have yet to fully realise that systems of provision that cumulatively develop produce good quality care.

An institutional focus on outputs

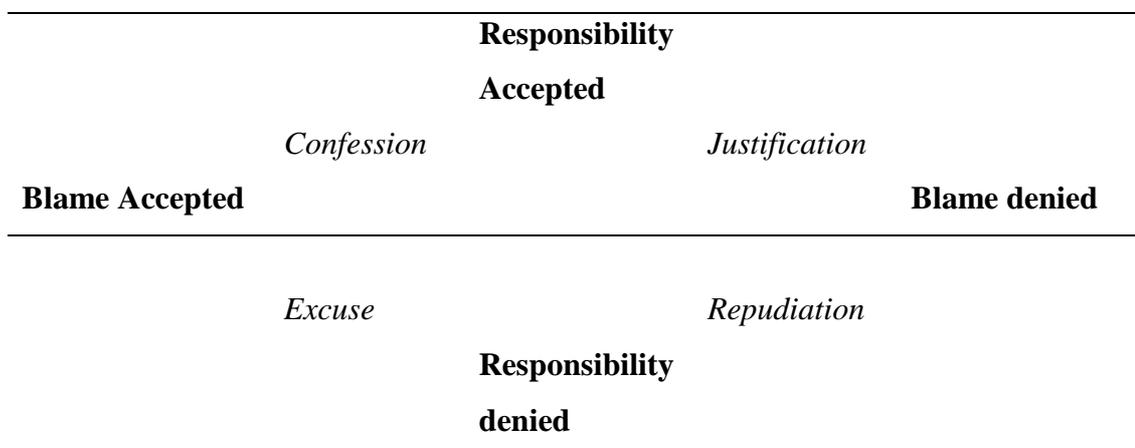
The result of a culture of ageism is a focus on outputs of service without drilling down to see if these are achieving outcomes for residents. Chapters 5 and 6 show how this focus was replicated by managers' attitudes towards service provision and the organisational culture of the service. Resident's expectations were focused on outputs rather than outcomes, which were only discussed indirectly in the context of a particular service output.

Residents across the studies had low expectations of care and felt their physical frailty should be embodied in the service provision. However, neither the service nor the inspectorate had an impact in terms of altering or challenging these expectations. In the case of the services there was clearly a motivation to maintain low expectations because it meant there was less pressure on provision. The low expectations also served as 'assurance', helping managers to justify the lack of empowerment and choice they offered. In the three privately owned services there was tension between profit driven and social justice driven modes of production, which were incompatible without a substantial rise in charges. It is important to point out that the focus on outputs was not the result of cynical exploitation of residents or purposefully offering a poor service, rather managers were constrained by a lack of resources and hamstrung by an inspectorate that continuously shifts the goal posts of quality.

Understanding a lack of service improvement

The question of *accountability* was a key factor in barriers to service improvement. As shown in Figure 2 Bull and Shaw (1992) build on Lyman and Scott's (1970) analysis of accountability, their conceptualisation is helpful for analysis of the level of service improvements in each of the case studies.

Figure 2: Conceptualising accountability



Source: Bull and Shaw (1992: 641)

The managers across the four case studies demonstrated examples of all four of these ‘accounts’ of inaction against inspection requirements. In CH 1 the manager initially gave both *justification* and *excuses*, before finally resulting to *confession* in the final interview when the threat of punitive CSCI action became real. CH 3 followed the same trajectory as CH 1 except there was still little contrition at the end of the study and the manager was still either making *excuses* for some failings and even exhibiting *repudiation* for the requirement on her to gain her management qualification in care; she felt that her experience of twenty-five years should count as a proxy to the qualification.

In CH 2 the manager made an *excuse* about the main failing, which was the mis-handling of medication, blaming it on an uncharacteristic mistake made by one of her senior staff. She thought the CSCI should have given some leeway on this issue because she argued it was so uncharacteristic. The CSCI could not confirm this *excuse* so an immediate requirement was issued.

In CH 4 where all of the requirements regarded documentation or environmental changes the manager made *excuses*. She accepted these were faults but blamed head office for keeping the documents rather than accepting that she should have insisted they were kept in the home.

The function of the CSCI and its limited ability to hold services to account meant that managers could hide behind the forms of accountability (see Figure 2) above without being forced or persuaded to change.

Burden of inspection

Staff and managers rejected elements of inspection and resented the burden it placed on their services. There were three sets of pressures directly related to complying with inspection that managers and staff found frustrating:

1. The administrative burden of complying with standards
2. Raised costs of complying with standards, in the context of decreasing budgets
3. Standards driving care rather than care driving standards

Grievances about these issues provided extra encouragement to defy inspection as far as possible. Points 1 and 2 primarily related to the increased cost and resources required to provide care that is regulated by the CSCI. This related to the control councils had over fees. Point 3 reflected inspectors' and staff opinion that they had to implement aspects of care provision they felt were only there to serve the metrics of the inspectorate and were actually having a negative impact on residents.

CONCEPTUALISING THE CSCI'S APPROACH TO INSPECTION

The influence of new managerialism

A new managerialist ideology has shifted the bulk of social service provision to the private sector (Gilbert 2005). This has led to the choice of provision sitting with the citizen, or consumer, who in reciprocating this choice has to be responsible for the choice made. These choices are supported by a government that provides quality assurance via service agreements, contracts, detailed performance data requirements and other managerialist techniques (Harris and McDonald 2001; Turner and Martin 2004). Skidmore et al (2004) advocate this approach by steering providers towards 'desirable regulatory outcomes, rather than specifying how they are to be achieved from the centre' (Skidmore, et al. 2003: 23)

Residents in this study often suggested they did not want to engage with choice and associated risk and instead preferred to devolve this to family or the service. This finding raises the question: should we be encouraging residents to take a greater responsibility under notions of active citizenship or should we accept that residents want paternalistic support from the state and their families? The evidence from both this study and others clearly suggests that where given the opportunity residents want to have a say in their own care (Department of Health 2006). It is clear that inspection could do more to support and encourage that process, both directly through support and partnership working with service providers and directly through better communication and engagement with residents.

However, Ferguson argues that:

‘...the philosophy of personalization is not one that social workers should accept uncritically’ (Ferguson 2007: 387)

and I agree. Ferguson uses the case of social workers, but I think this can be equally applied to the social care profession. He argues that concepts of active citizenship and new managerialism are actually stigmatising ideas of dependency, social justice and professionalism of social workers. Reducing notions of good care to personalisation serves to marginalise professionals and place unfair levels of responsibility and accountability on service users. This study has shown that a lack of empowerment is negatively affecting residents, but also that empowerment itself is not the answer – residents still wanted to be able to rely, and in some cases depend, on services. What is required is a balance, but the CSCI inspection regime did not support this approach. Inspection has been so focused on linear, technology led accountability processes it has failed to support and facilitate this working. Instead the concept of personalisation forms a layer of rhetoric that residents and services have yet to fully understand or embrace. As Munro argues in the case of social work:

‘the process of making human services including social work "auditable" is in danger of being destructive, creating a simplistic description of practice and focusing on achieving service outputs with little attention to user outcomes’ (Munro 2004: 1075).

My findings agree with Munro (2004) and others (see for example Carey 2006) and clearly show that a new managerialist form of inspection leads to a diversion of resources to technology, software, consultants and technicians and paradoxically, as it goes against policy aims, constrains service user choice. The Inspection Record (IR), associated computer database and those processes expected of care services by the inspectorate, in terms of care planning and the AQAA (which was designed to be internet-based but two of the case study services were not connected to the internet), have served to divert focus from service users towards paperwork and technical aspects of providing care. Chapters 5 and 6 clearly show this shift and the frustration it caused for managers, staff and inspectors.

The modernisation agenda had a big impact on inspectors as it produced changes in their system of working: a reduction in inspections, an increase in data analysis and ‘desk work’, and a shift to home-based working. It was clear inspectors were not happy about their change in role and what they saw as marginalisation and deprofessionalisation. This finding is supported by a Unison (2007) study that showed inspectors had a lack of confidence in the CSCI leadership and the new inspection regime. They also felt alienated by the closing of offices and were worried about the lack of team dynamics that would be caused by home working:

‘When we shift to working from home there’s going to be no one to check things with, or have a chat about, you know... ask about a certain home or how another inspector would deal with a certain situation, I don’t think that’s good’ (Inspector CH 4)

Inspectors felt their job was being increasingly guided from the top-down, with little concern for their views. Although inspectors were consulted on changes and some were part of advisory panels the inspectors in the case studies felt that much of the consultation was tokenistic and was being imposed despite unhappiness at changes.

There was clear evidence in the form of IBL, the development of KLORA guidelines and the AQAA, of the ‘Administrators Prerogative’ in policy making (Croley 1998). The CSCI leadership was slowly changing standards without formal changing of NMS or care home

regulations and therefore any act of parliament. They achieved this through reinterpretation of their inspection and judgement guidelines

Self-governance: too much too soon?

The shift to risk-based inspection places a greater emphasis on self-governance through introduction of the AQAA. The CSCI are shifting accountability to service management, and stepping back to provide the 'check', or safety-net if anything goes wrong. They justified this through the implementation of a stringent registration process and comprehensive training requirements for all care home staff. However, this system has not been successfully embedded everywhere. Self-governance success requires: long-term capacity building; effective information and meaningful participation; a co-production process and support to develop skills for decision-making. Each of these attributes requires a high level of skill and capacity and data from my studies shows that not all services and service managers possess the knowledge and skill to self-govern. Both managers who had not achieved their NVQ in care or management were finding it very difficult to implement changes required by the CSCI. For the problems of relying too heavily on self-reporting CSCI needs to look only to the US where self reporting has failed to induce significant improvements in nursing home care (Harrington 2001).

Inspection stifling innovation and improvement

There was a real feeling that inspection was stifling innovation. Managers were concerned that most of their working day was consumed with meeting standards and spoke of the burden of bureaucracy that inspection creates. Stifling of innovation was found in studies of the US healthcare system in the 1990s (Brennan and Berwick 1996; Walshe and Shortell 2004) and the pressure on services in this study was certainly very high. It would be interesting to see how this pressure was channelled in services that were performing well against CSCI standards to see whether pressure created by inspection had led to innovative services, or whether the burden was simply being managed more effectively.

There is a danger that extra pressure creates resistance and inertia as happened in CH 1 and 3, which made little progress on the requirements issued after inspection. Findings from this study suggest that the only way to break this and ensure improvement is to adopt an approach with poorly performing homes that is compliance-led and works in partnership with services to build on strengths and support improvement. This aspect of regulation has

been marginalised in favour of inspection and standards-led goal setting. There is also little emphasis placed on the recommendations in the report, which could be more productively utilised as ‘catalytic feedback’ (Braithwaite, et al. 2007) if their cumulative importance is emphasised. The managers in the case studies largely ignored recommendations because they were either too preoccupied with requirements or knew they were not enforceable and therefore decided they were not important. As the Line Manager of CH 2 claimed during my second visit where he dismissed the idea on acting on any of them:

‘well they’re just recommendations... I mean they suggest what we should do but we don’t have to do it if we don’t agree’ (Line Manager CH 2, interview 2)

The existing burden of requirements and lack of compliance-led inspection created a situation where managers were unable to complete requirements so were certainly unable to focus on recommendations with a view to forward planning and step-wise improvement.

A devolution of responsibility to commissioners

Inspection is only part of a patchwork of regulation that is interlocked and interconnected but that often works independently. The CSCI modernisation plans have devolved further powers to local councils. The devolution was well underway during the cases studies and there was evidence of considerable fragmentation and duplication. Managers were particularly annoyed at the duplication between local council quality monitoring and CSCI inspections, there was duplication not just in terms of frequency and structure of site visits but also in terms of the types of submissions. The problems were exacerbated because there were often different forms and methods of submission, so for example, the contents of the CSCI’s new AQAA self-assessment could not simply be duplicated and given to the council, as they wanted things in a different format. This is an example of the lack of joined-up working between public sector organisations that promotes inefficiency and frustration. Similarly inspectors spoke of a lack of formal routes of communication between inspectors and council quality monitoring teams meaning useful information was not being shared and the bureaucratic burden on services was increased as a result.

The launch of the World Class Commissioning (WCC) framework has *de facto* devolved some regulatory powers to local councils because they must ensure they are ‘managing

local health systems' and 'making sound financial investments' (Department of Health 2007c). Public Service Agreement 19 also states that local authorities must ensure better care for all (HM Treasury 2007). According to the inspectors and managers in this study local councils now have quality assurance teams and contract monitoring teams (usually both) to monitor quality and assure they are commissioning high quality services. There is no prescription from national government over quality monitoring, the CSCI provide the national check, but according to inspectors in this study councils tend to stick quite closely to the CSCI NMS, but this did not result in similar bureaucratic requirements.

The relationship between the CSCI and councils was negatively affected by the dual role of the CSCI as an inspector of individual services and councils. The inspectors had very little communication with monitoring teams in councils and they believed it was because of this uneasy organisational relationship.

Through its own evolution and the development of the roles of councils under WCC the CSCI appeared to be slowly devolving power to local councils, certainly in terms of enforcement. As CSCI punitive action against services was such a cumbersome process new performance assessment outcomes frameworks for councils (CQC 2008) place responsibility on them to deliver the following:

- Performance management sets clear targets for delivering priorities (p 42).
- Shape the market to improve outcomes and good value (p 43).

The CSCI and its successor body have begun this process by delegating responsibilities to council contracts officers and adult protection co-ordinators to investigate areas of concern. Contracts offices are able to temporarily suspend placements to services and therefore use market principles to force improvements. It is clear that this method of enforcement is problematic not least because certain areas have a shortage of care home beds, which means suspending registrations can cause capacity problems (Furness 2009).

A suitable model to induce service improvement?

The idea of strengths-based and compliance-based models of regulation have their foundations in the work of Etzioni (1961) who described three types of mechanisms for gaining compliance from an actor: normative, coercive, and remunerative.

According to Etzioni's (1961) analysis normative mechanisms induce compliance either by ensuring the regulator and the regulatee have mutual goals, which in the case of social care should be resident wellbeing, or through the legitimacy and authority of the person requesting action (the inspector). According to Matland (1995) who developed Etzioni's model in the context of policy implementation:

'For administrative implementation, where levels of conflict are low, normative compliance mechanisms are generally sufficient. The orders given are perceived as legitimate, and there is little controversy that might lead to subversion.' (Matland 1995: 161)

Essentially in this scenario the regulatee subscribes to the authority of the regulator and accepts their expert opinion. For regulation to work in a normative fashion it relies on the service (regulatee) to believe that the inspector, the person who is detecting, judging and enforcing, is an expert and has a greater knowledge of the social care process than the management of the service. I have shown in this research that this is often not the case and managers question both the expertise of the inspector and motives of inspection, which some saw as at least in part a self-serving exercise on behalf of the regulator.

System tension between the CSCI and inspectors further undermined the authority of the inspectors because they were clearly frustrated by the erosion of their professional judgement and autonomy to exert a street-level influence.

A coercive mechanism threatens sanctions for failing to comply with a request for action, Etzioni (1961) described this mechanism as a last resort, which could be expected to be effective since it is clear and easily monitored. However, as this research has shown the success of coercion is dependent on the efficiency of the mechanism employed to enforce it. The regulator can have ultimate coercive power, in the case of the CSCI the ability to close a service, in theory, but if in practice the process is long and cumbersome the threat becomes empty, and the coercive mechanisms less effective. This is clearly shown by the many timescales for improvement that were flouted by the four case study services.

A remunerative mechanism must 'include sufficient incentives, often additional resources, to make the desired course of action attractive to the agent' (Matland 1995: 161). The only

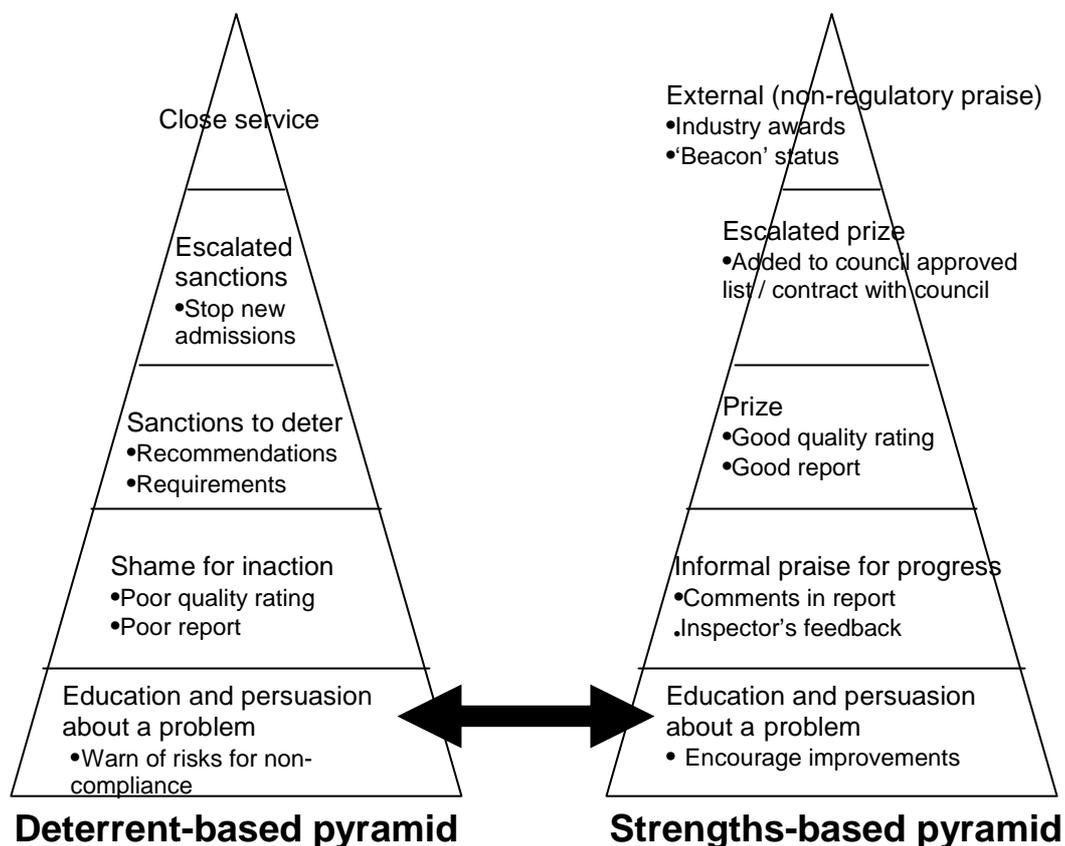
remunerative action residential social care regulation offers is through an indirect influence over council commissioning. In reference to this the manager of CH 1 explained, he was operating in a vicious circle where he wanted more money from the council to make it possible to improve the service, in the form of a secure block contract, but the council were not prepared to place any more people in CH 1 until he improved the CSCI report and NMS scores. However, he felt that he had a sufficient number of private residents not to be unduly concerned. This suggests there is no cooperation between agencies to utilise this method of persuasion. The case of CH 1 does, however, provide an argument for the need for better joint working between the regulator and councils. If there could be a joint mechanism developed whereby improved ratings from the regulator led to an increased chance of funding from councils then a remunerative element of compliance could be built into the regulatory framework.

This research has shown that the CSCI was failing to use any of these three mechanisms of compliance effectively.

Realising that there are a plethora of incentives and disincentives within social care regulation Braithwaite et al (2007) examined the differences between regulation policies of older persons nursing care in the UK, US and Australia. They found that the US tended towards a deterrent, risk-based approach with coercive sanctions to effect change, but Australia had paradigmatically shifted its nursing home regulation towards a model based on continuous improvements of strengths, based on a normative set of goals. My data suggests that the CSCI model has struggled with conflicting pressures and evolved into a model that takes elements of both strengths-based and deterrent-based regulation, but which under its recent development and as it amalgamates with the Healthcare Commission and Mental health Act Commission to form the Care Quality Commission (CQC), has shifted further down the deterrent, risk-based route. This is evidenced by the change to a three-year inspection cycle, based on detailed risk-assessments from self-reported data. Under this model it is harder to focus on continuous improvement because contact with services is less frequent and intense. Even services rated 'poor' that will still have yearly inspection visits are subjected to a lighter, risk-based assessment necessitated through financial constraints and justified as modernisation.

Building on the work of Braithwaite et al (2007) I have developed a typology of the CSCI's 'effector' process (see Figure 3) which shows how the CSCI tries to use elements of strengths based and deterrent-based philosophies.

Figure 3: Typology of the process to affect change in the regulation of older peoples' social care



(Adapted from Braithwaite, et al. 2007: 319)

The CSCI can be broadly categorised as deterrence-oriented, with a strong focus on identifying deficiencies, putting agreements in place for these to be improved and imposing penalties and sanctions (see Figure 3). However, in practice my research has shown this is not how the regulator works. The processes in the bottom two segments of the deterrent-based pyramid were routinely used and according to CSCI statistics are often enough to force services to improve. However, where the CSCI reaches the third tier, 'sanctions to deter', on the deterrent-based pyramid services in the case studies either chose to ignore them or did not have the knowledge to remedy them. Transgressions frequently went unpunished often failing to meet more than one timescale for action because the process of 'escalated sanctions' was so cumbersome. This meant the local

offices resorted to strengths-based methods to foster improvement using informal encouragement, discretion to create local level solutions, and regular Random Inspections (RI's) to follow up a services' progress.

The incentive of a good report is used to encourage improvements under the rationale of active citizenship. Residents and their families must access, critically engage and then make the 'right choices' based on the information within the report. However, this incentive is marginalised when considered in the context of data from this research: only two relatives and one resident were aware of the CSCI's annual report and only one relative had actually consulted it before their parent moved into the home. Managers were aware of this lack of consultation and felt that negative reports were not having a noticeable negative impact on resident numbers. Only CH 1 expressed any negative outcomes as the result of receiving a negative report and that was because the council would not block purchase any beds, a practice which is now coming to an end anyway as a result of the new World Class Commissioning (WCC) framework (Department of Health 2007d), which places the emphasis on purchasing services that are tailored to the individual.

Support is supposed to be provided by other non-governmental organisations such as the GSCC and by training and qualifications that all managers and staff are supposed to acquire to do their respective jobs. The strengths-based elements of the pyramids are provided outside the direct scope of regulation, for example through commissioning bodies or industry awards. The problem with the system is that there is still imperfect information about this support and a lack of incentives for some managers to use it.

The goal of the CSCI when it set out was to both improve standards within the care sector and catch those services that were failing to achieve minimum standards. To enhance this there should be a robust and explicit strengths-based agenda with the safety net provided by strong punitive sanctions if a service continually fails to improve. The findings from this thesis suggest the CSCI are failing to implement this system effectively at the moment. The current system has marginalised inspectors' knowledge and experience in favour of a risk-based system based on data analysis, where any inspector can go to any home without prior knowledge of the service. In doing this the CSCI has lost many of its beneficial strengths-based facets, such as reliance on the professionalism of inspectors and the use of

professional judgement and experience to guide inspection findings and find the best mechanisms to induce improvement.

Theorising inspection

Writing about evaluation Weiss (1987) argues that the programmes being evaluated are borne out of political decisions, which means:

‘They emerged from the rough and tumble of political support, opposition and bargaining. Attached to them are the reputations of legislative sponsors, the careers of administrators, the jobs of program staff and the expectations of clients’. (Weiss 1987: 49)

These considerations provide a framework to theorise inspection in the context of new managerialist ideology, and the technical influence of the administrator (CSCI) (Corley 1998). I have argued that inspection and a vision of service provision both stem from political considerations. Claims from CSCI suggest they envisage an inspection process that places service users’ views at the core of assessment. However, data in this research shows that the function of the system is creating barriers to improvement. Rather than helping to change social and institutional structures within which the problems for the services were generated and sustained inspectors were forced to use a model of inspection that focuses on a set of discrete standards, measured in terms of policies and procedures in place, specific output responses in surveys, problems identified and improvements required.

The CSCI vision has been obfuscated by the technicalisation of inspection and the momentum of the regulatory agency, which because of the size of the organisation and the systems in place has become difficult to change. I have built on the arguments of others to contend that the technicalisation of CSCI’s vision of improvement into standards has meant that, despite claims to the contrary, focus of inspection has been predominantly on ‘quality as measured’ rather than ‘quality as experienced’.

Where quality is viewed as measurable judging quality takes on the characteristic of what Stake and Schwandt (2006), when discussing of the quality of evaluands, term ‘thinking

criterially' (Stake and Schwandt 2006). This means an explicit transformation of evidence gathered into the appropriate standard for it and 'is more or less an experience distant undertaking' (Stake and Schwandt 2006: 407). Conversely:

'Quality-as-experienced starts from the view that quality is a phenomenon that we personally experience and only later make technical, if need be. This view emphasises grasping quality in experience near understandings, that is, in the language and embodied action of those who are actually undergoing the experiencing of a program or policy.' (Stake and Schwandt 2006: 408)

The focus on inspection in terms of its technical function does not allow for this level of analysis. Instead it focuses on 'experience-distant', criteria based measurement against standards.

As the process of regulation shifts ever further to focusing on 'experience-distant' criteria inspectors are increasingly being treated as 'moral dopes standing mute at the margins of everyday responsibilities' (Gubrium 1989: 197). Rather, they are sensitive to 'the consistencies and contradictions between what they claim to know about clients and what they are requested to document' (Gubrium, Buckholdt et al 1989: 197). It is this valuable tacit knowledge and understanding that must be better utilised to overcome the current barriers to improvement of inspection.

There is a clear tension in inspection that results from the interaction between standardisation, what Gubrium, Buckholdt and Lynott (1989) call a 'descriptive tyranny of forms', and local level decision-making. However, evidence from this study suggests that inspection has not completely lost all narrative and contextual elements because there were examples of flexibility in the discretion some inspectors used.

It is not enough to simply want to know the outcomes of inspection but also why those outcomes appear—or fail to appear. Inspection in its current form and the progression it is making under a 'modernisation' agenda is in danger of losing this enlightenment, quality as experienced aspect by becoming a 'tick box' exercise driven by forms and technology. The Inspector of CH 4 told of her dismay at this prospect:

‘I don’t want us to become like the Healthcare Commission where they go in to a hospital and sit in a boardroom for two days without even going into the ward’
(Inspector CH 4)

While it is important to emphasise these discretions have not been eliminated, as the CSCI admits ‘there is still a big gap between vision and reality... most users still experience ‘one-size fits all’ care’ (CSCI 2009). The encroachment of further target driven emphasis despite the rhetoric on outcomes is moving the CSCI in a retrogressive direction, which is serving to reinforce a one size fits all model of care.

The CSCI as a ‘critical foe’

The concept of a critical friend has its foundations in educational reform of the 1970s:

‘A critical friend can be defined as a trusted person who asks provocative questions, provides data to be examined through another lens, and offers critiques of a person’s work as a friend. A critical friend takes the time to fully understand the context of the work presented and the outcomes that the person or group is working toward. The friend is an advocate for the success of that work’ (Costa and Kallick 1993: 49).

The notion of a critical friend could be applied to the act of inspection with inspectors providing a critique of care. However, data from the case studies suggests that rather than a ‘friend’ the CSCI acts as a ‘foe’. The term infers opposition and this reflects the adversarial relationship found in the case studies. The elements that represent the notion of ‘friend’ – ‘taking the time to fully understand the context’, being an ‘advocate for success’ - were noticeably constrained for inspectors both by the technical constraints of the inspection process (user-distant, critical measurement) and the deterrence-led approach that prevented inspectors working in partnership with services to offer support and be ‘an advocate for success’.

This focus coupled with the burden of paperwork felt by services led to the perceptions from managers and staff that for the CSCI inspection is the purpose itself, rather than improvements in quality. It was clear that this led to frustrations for inspectors, who felt

that although the criteria are useful indicators of quality they are not necessarily good proxies for actual improvements and improved outcomes for residents. They would have liked more time to spend ascertaining the experiences and views of inspection and learning from experiences of a home with a view to drawing on aspects of partnership working.

Unfortunately in the context of 'modernisation' and resource cuts this was not possible and inspection, although figures will show that it is raising standards against the NMS indicators, is actually taking a retrogressive approach to improving care because the technicalisation of the process of both care provision and inspection are acting as barriers to improvement.

This thesis has taken a critical stance against the CSCI's modernisation of social care inspection. While I stand by my endeavour to hold a mirror up to inspection my conclusions must be taken in the context of improvements created by CSCI. Statistical data (see CSCI 2009) shows an improvement in quality as measured against the baseline of NMS and data from this study show stakeholders think at least some improvements have resulted from the tightening of regulation. The standards are not the sole problem; they set out a well researched vision of social care. However, the new managerial approach to implementing these standards is clearly not working to improve all services.

POLICY AND PRACTICE RECOMMENDATIONS

These conclusions expect a revision of current government policy and CSCI practice. There are numerous policy pressures that influence the way inspection is formed and delivered. Never more so than now have economic pressures been quite so prominent and the argument I make for a broader more inclusive inspection process that gives inspectors the opportunity to spend more time with residents and work in teams if appropriate would likely be dismissed in policy making circles as idealist and unaffordable.

In the context of the critical analysis within this thesis I now offer policy and practice recommendations.

The first set of these are made without the constraint of current financial budgets, but I do not apologise for this fact as clearly part of the problem is the current chronic under-

funding of social care (HM Government 2008), and this should be addressed politically alongside restructuring of the social care system.

In acknowledgement of prevailing political opinion and economic constraints I also offer a second, more pragmatic set of recommendations, which do not offer a route to eliminating all of the criticisms in this thesis, but which I consider achievable in the context of structural constraints.

In an ideal world...

The findings in this thesis paint a reasonably negative picture of care homes. In all four case studies the main reason given by the managers for failings was the lack of resources. In the context of these findings, and HM Treasury's estimate of the £6 billion funding black hole (HM Government 2008), there needs to be fundamental changes to both the care delivery and inspection systems.

The Treasury itself states that a world-class care system would require a huge amount of new money (HM Government 2008). This could be achieved in two key ways:

1. Social Insurance – people insuring against their care needs in later life, either through active (people compelled to invest in a state-led and/ or private-led insurance scheme) or passive (no compulsion but risk no or bare-minimum levels of care if opt-out) compulsion.
2. An increase in (income proportional) taxes to fund an improved and universal care system.

Accepting the principles of social justice, by far the most equitable and just means of achieving this is through increasing taxes to give older people a more dignified final chapter in their life. This would allow all services the budget to increase their staffing ratios, and 'professionalise' staff through increased training and higher salaries. By professionalising the workforce staff will be in a position to innovate and, because of a greater sense of professional responsibility, will be prepared to spend more time on record keeping and planning. A closer ratio of staff to residents would also allow staff to spend more time with residents, engaging them in activities or simply 'having a chat', which my findings suggest was valued above almost everything else by residents. More proactive and

meaningful engagement of residents must also include empowerment and an increased emphasis on residents guiding their own care. This needs to be much greater than in the current system that only tokenistically attempts to engage residents with their care plans. Engagement should not be driven through a technical process of filling in required forms, which it is currently, rather it should come through a shared focus and belief by residents that their input will be valued and regarded as highly as the input of staff.

Without these changes it seems inevitable that the institutionalism I found will continue to be replicated in services. A better resourced system will both improve care, but also allow more effective regulatory compliance because the services will be in a position to better deal with the regulatory burden (more staff will free other staff time to spend on compliance).

However, the regulatory burden should also be reduced. Instances where record keeping was being carried out primarily to re-enforce the role of the regulator must be eliminated. What is required is a focus on the tacit knowledge of inspectors and their freedom to weigh-up complex judgements based on their own knowledge and experience as opposed to having to refer to a set of KLORA guidelines. They should also be able to discuss improvement with services. They should be given reign to offer constructive advice where they think it is necessary and share good practice they have observed elsewhere. This can only be achieved through a system built on the premise of solidarity and mutual trust, where providers are happy to support one-another and work together with the inspectorate in a spirit of collective endeavour and responsibility. To achieve this there needs to be a rethink of the system of social care and a shift away from an ideology of new managerialism and profit driven efficiency towards a system based on social justice and collectivism.

A more pragmatic approach to change...

I am wary of expecting too much from policy makers. However, this thesis makes the case that despite saying the correct things the CSCI has developed a system of inspection that prevents a successful outcomes focus. The successor to the CSCI, the CQC, is re-evaluating inspection methods in 2010 and I argue it needs a reorientation of focus away from technology-led audit to a more enlightenment, quality as experience based inspection

programme. The following recommendations take a more pragmatic view of inspection and accept that the whole-scale structural changes recommended above are unlikely to find their route into practice. However, these recommendations do represent a fundamental refocusing towards ‘quality as experienced’ (Stake and Schwandt 2006) by the people who live in care, rather than the ‘experience distant’ (Stake and Schwandt 2006) records that supposedly represent the quality of their care and which currently take up a disproportionate amount of inspectors time.

There are a number of ways of improving service users experience and engagement with the existing inspection regime:

1. Empowering residents and their families through better communication with the general public about the rights and responsibilities of service providers and the role of the regulator in assuring these.

This could be achieved through a longer engagement process during the inspection facilitated through a longer inspection period. This would allow inspectors longer to talk to residents and relatives, which my findings suggest is key to success.

I would also advocate the reintroduction of lay inspectors, who should either have direct experience of care home living themselves or have had a family member or close friend resident in a service and therefore have knowledge of the workings of a service.

2. Making service users voices louder and more active in inspection, which will only be realised if point 1 is achieved.
3. Changing culture in both the inspectorate and services through a model of regulation that focuses more on a partnership approach, including allowing inspectors to build upon *catalytic feedback* using their tacit knowledge to discuss options with inspectors during the feedback process.

In order to enhance the support and improvement function of the new regulator it should offer greater practical guidance to services in the form of best practice templates for care plans and other record keeping functions. Not every service

would have to adhere to these exact guidelines; if a service has a unique or novel way of planning or record keeping that fulfilled the necessary requirements then this would be acceptable. The best practice guidelines should evolve and inspectors should be encouraged to share best practice seen elsewhere with services that are failing to meet the standards.

There is also scope to improve the inspection process and outcomes:

- Inspectors to be not just be allowed but encouraged to reflect more *in* practice and not be so constrained by guidelines (such as KLORA)
- Inspectors should be encouraged and supported to regularly reflect *on* practice and suggest both national and local-level initiatives and solutions.
- Involving service users more in the development and changes to inspection practice when ‘shifting the goal posts’ – to prevent further distance from residents’ direct experiences.
- Using their understanding of outputs to create links to outcomes – this can only be achieved through more in-depth interviews with residents.
- Halting the continuing technicalisation of inspection.

This could be orchestrated from a ‘top-down’ level, which would require a re-thinking of KLORA to create a balance between consistent standards and local-level flexibility. I have demonstrated that discretion was already being used at the local-level in the case studies despite the ongoing tightening of criteria governing judgements; so to facilitate this officially is not compromising current practice.

Alternatively, and perhaps more realistically in the current financial and political climate, inspectors should reflect on ways to exert discretion. This should both build on existing discretion, but also develop new and innovative methods to improve inspection process and outcomes. In this I take heart from a previously used quote by Evans and Harris (2004) that suggests:

‘...by creating rules organizations create discretion’ (Evans and Harris, 2004: 883)

It is not enough to simply want to know the outcomes of inspection are but also why those outcomes appear - or fail to appear. This can be achieved by marrying the concepts of audit and enlightenment evaluation (Shaw 1999).

Better joint working with councils

There is clear evidence that under the WCC strategy further responsibility over quality assurance is being devolved to councils. Without any additional funding they must now meet quality assurance and contract monitoring commitments under PSA 19. The CQC will need to work better with local councils at the level of the on the ground inspector. This will require a removal of barriers that existed between the CSCI and council as a result of the dual role of the CSCI as inspector of councils and inspector of service providers (i.e. if the council is purchasing services from poorly performing services it would often be marked down by the CSCI).

This is necessary for both the successful regulation of services and to try and eliminate the duplication services currently face.

The CQC: Talking softly while carrying a big stick?

In some senses these recommendations are irrelevant. There is little doubt, in this current economic climate and with a continued emphasis on new managerialist ideology, that the CQC will continue down the risk-based route. For evidence of the CQC's direction one need look no further than the comments of the new CQC Chairwomen Barbara Young who claimed the CSCI had been 'running the finger around the toilet bowl' (Carvel 2008b) without many statistical or risk-based tools to target inspections and encourage or even force improvements.

Chairwomen Young also emphasised the deterrent-based angle the CQC will adopt, although she maintained it would try to also exert a strengths-based influence. She claimed the CQC would aim 'to talk softly but carry a big stick' (Carvel 2008a: 1). However, under the Care Standards Act 2008 the CQC has new powers to give public warnings, fine providers or suspend registration if they do not comply, rather than having to immediately reach to the 'ultimate sanction' of closure. The new powers in the CSA 2008 address inspectors' concerns about the inability to enforce change if providers continually fail to

meet timescales for improvement. Under the new powers of the CQC CH 1 and CH 3 could be warned, fined or have their licence suspended, rather than before when the only real enforcement action was to cancel registration and close a service. There will need to be further research to determine whether these new powers serve to improve compliance.

Despite the strengthening of the punitive angle there is a need for a stronger supportive dimension, which focuses on helping services improve rather than attempting to force them. To do so greater emphasis should be placed on ‘strengths-based’ inspection would help services, especially independent providers who have no internal assistance. But financial and bureaucratic constraints mean that this service has been removed from inspectors and placed in the hands of other non-governmental organisations such as the GSCC. However, while there are avenues of support available it seems that information has not yet disseminated to some care home managers the distinction between the role of inspectors as assessors and support and advice provided from other third party organisations is not clearly mapped.

REFLECTIONS

Further research

This research has raised a number of questions and there is scope for number of further research projects:

1. It would be useful to conduct a similar qualitative study of compliant services to determine whether the same problems were evident. The assumption is that because they are compliant with standards the services will exhibit a much more user-focused service and not be struggling to adhere to standards. However, as I have argued I suspect many of the problems are systemic within social care, but have different levels of impact.
2. In light of the lack of effectiveness research it would be interesting to see further research into how frequently requirements are ignored and how many consecutive timescales can be missed before further action is taken. It would also be interesting to conduct a wider study of inspectors to examine the tactics they use to enforce

standards, and the street-level techniques they use to either complement or usurp prescribed protocols and guidelines.

3. In adherence to the current political favour for research centred around controlled studies it would potentially be possible to design a study of effectiveness using a stepped wedge design (See MRC framework on Complex Interventions (Craig, et al. 2008)). A group of comparable homes would be allocated into study arms, one of which receives an inspection at the beginning of the trial and the other which receives an inspection at the end of the trial period. This would be possible because inspections function on a yearly cycle. I would expect the study to involve both a quantitative effectiveness element and a qualitative element and the design could use outcomes from this study as indicators.

Unique access

Travers (2007) has talked about the difficulties of accessing inspection and I was in a unique position of being able to observe and inspection and then interview the major stakeholders over a nine-month period. The findings from this study are therefore the result of a unique study of the CSCI.

Reflexive inquiry?

I was surprised by the number of study respondents who asked me for advice during the case studies. Questions came from all groups:

- Managers and staff asked me questions about their service and whether I thought it represented good practice; they also enquired about the NMS and whether I thought aspects of the service would meet the relevant NMS.
- Relatives wanted to know what I thought of the service and they had questions concerning complaints; they often wanted my normative opinion on both good quality inspection and care.

I was careful to decline these requests and aspired to remain neutral as a researcher. This line of questioning suggested that the power relationships of the interviews were not always as a researcher – staff member / manager as I had intended, but that I was occasionally seen as an ‘official’ affiliated to the CSCI.

APPENDICES

APPENDIX 1: SYSTEMATIC REVIEW PROTOCOL

Title

‘The impact of the regulation and inspection process on residential care for older people’.

Background

Effective Inspection – Why conduct a Systematic Review?

There is little existing evidence to suggest what constitutes effective inspection in social care, or whether effective inspection promotes factors which older people claim improve their lives. In the UK the Care Standards Act (2000) states that the regulatory body shall have the general duty of keeping the Secretary of State informed about the quality of services, and ‘shall have the general duty of encouraging improvement in the quality of Part II services (*those that are required by law to register with the regulatory commission*)’ (2000). It is unclear what impact inspection has on outcomes of social care or what outcomes designate effective inspection. There are various ways the inspection process could be judged to improve quality of care, including:

- Improving care homes’ performances against a set of measurable standards
- Improving the lives of residents as measured, for example, by an increase in participation, or increase in measured objective well-being.
- Inducing an increase in staffing levels, which research in both Australia and the United States has shown corresponds directly with improved care (Braithwaite 2001; Harrington 2001).
- Impacting on whether care is purchased from a particular home. As yet there is little international work on establishing links between care home performance and purchasing of residential care services, either by individuals or by government authorities (Harrington 2001).

It is unclear whether inspection works in all instances, in all older persons’ care homes, or whether it has a greater effect on some homes’ compared to others and particular outcomes over others. This protocol is driven by the necessity to improve the knowledge base of social care inspection and inform policy making by facilitating decision-making that is well informed by evidence.

CSCI has very little information on the efficacy of the inspection process, which suggests there is a dearth of accessible research. This apparent lack of impact research is not just limited to social care inspection. There has been little policy research done in the UK on outcomes research *per se*, with the Department of Health instead focusing much of their work on monitoring the impact of legislation (Macdonald 1999). The rhetoric of governments, built on or influenced by the third way pragmatism of ‘what counts is what works’ and the subsequent belief that policies should be ‘evidence based’ is left wanting when there is no systematic body of evidence on the benefit and costs of inspection and regulatory regimes (see Hood, James et al. 2000; Boyne, Day et al. 2002).

A lack of existing evidence

The apparent lack of research on effectiveness seems to represent a certain level of scepticism social care researchers have towards the epistemology of evidence based policy making and its affiliation to health based research. However, in order to be accountable social care regulatory bodies, as regulators of government policy (or at the very least social justice), need to reflect on the efficacy of their work and establish a knowledge base from which they can begin to assess their performance. What this review aims to achieve is to begin to build a map of international evidence on the efficacy of social care inspection and help to inform evidence based decision making in the social care sector by systematically searching for, and analysing all relevant studies in the field of inspection and regulation of older people.

In conjunction there is also a need to build upon questions of efficacy and determine what makes inspection more or less effective. Within the UK there has been a paradigmatic shift to place service users, not just social care professionals, at the forefront of improving social care. In light of this inclusive direction and in concomitance with considering the impact and effect of inspection, it is necessary to examine why inspection has an effect (either negative or positive) on the users of social care and understand how the inspection process directly effects the individuals it aims to serve.

Objectives

The aim of this review is two-fold and it will be conducted in two separate parts:

C. **Effectiveness question:** Assess evidence for the efficacy or otherwise of the regulation and inspection process to improve living conditions and well-being in older people (over 65) living in residential care?

D. **Process question:** In what conditions are inspection and regulation more or less effective? How do service users view the inspection process?

In order to answer question A I will use the best available evidence from well-designed and explicit trials, whether randomised or not.

Question A will locate studies which show what works but they will not tell us why or how they do therefore I propose that the second part of this review will look at process issues. Question B will be answered using data from qualitative research and other types of process evaluations which reflect key contextual and implementation issues.

A descriptive systematic map of the research evidence relevant to answering questions A and B will be produced. Following this there will be an in-depth review and synthesis of the quality and findings of the studies.

Criteria for considering studies in this review

Types of studies

Objective A

Four types of study will be included in this section of the review. They will be (for details of inclusion thresholds for each design see **Quality assessment** section):

1. Randomised Control Trials (RCTs)
2. Controlled Trials using a quasi-random allocation (CTs)
3. Controlled Before and After Study (CBA)
4. Interrupted Time Series Design (ITS)

Objective B

Studies which examine the conditions in which inspection is more or less effective will be included in the review. They will be assessed using criteria developed by Kavanagh, Harden et al (2005), according to whether:

- (i) The aims and objectives were clearly reported;
- (ii) There was an adequate description of the context in which the research was carried out (including a rationale for why the study was undertaken);
- (iii) There was an adequate description of the sample used and the methods for how the sample was identified and recruited;
- (iv) There was an adequate description of the methods used to collect data; and
- (v) There was adequate description of the methods used to analyse data.

Timeframe of search

The review will cover material from 1991 to the present (2007). This time period has been chosen because 1991 is the year of the 1st annual report by the Social Services Inspectorate and is the first year where the effects of the influential report on “Caring for people” were implemented. This period represents the point in time when the decision was made to ‘promote decision-making processes and service provision which reflect the needs and wishes of users... and... aims to replace systems dominated by professionals with approaches based on partnership with service users’ (Department of Health Social Services Inspectorate 1991: 14). As the 1991 report by the SSI asserts ‘... these changes represent a substantial shift in the culture of the PSS (*Personal Social Services*)’ (Department of Health Social Services Inspectorate 1991) and began the shift to the emphasis onto the user involvement that we have in UK care services today. This timeframe also allows for similar trends of transition in other countries to be reflected in research, such as the influence in the US of quality standards being established in law in 1987 (Harrington 2001) and the regulatory shift towards evaluating outcomes for residents in Australia in 1989 (Braithwaite 2001).

Types of participants

Older people over 65, whom for reasons of frailty, or other conditions which require care, live in a residential care home (board and care home, or assisted living facilities). For the purpose of this review *Residential Social Care* is defined as a ‘care home which is

providing personal care' (CSCI 2006). There is a caveat to this definition in that there are occasions where care homes for older people accept residents who by virtue of their condition (such as the early onset of dementia), require the services that an older persons care home provides. I will not exclude a study in which a care home that provides a specific service for, and predominantly cares for (over 85%) older people but has a small minority of those under 65 because of their specific requirements.

This review does not tense include:

1. older persons' nursing homes, which provide skilled medical care.
2. residential care for children or adults where care is aimed at those people under 65, or people under 65 make up over 15% of the population.

There will be no limitations on language and interpreters will be used where appropriate.

Types of intervention

The intervention being measured is inspection, which for the purposes of this review is defined as:

Independently examining an institution to assess shortcomings in relation to official standards and/ or stakeholder views and evaluations.

Types of outcome measures

Objective A (Effectiveness question)

A range of outcome measures will be identified and analysed where appropriate. These may include:

1. Improvements in measured outcomes
 - As measured against a set of independently devised standards enshrined in law, which may include:
 - i. National Minimum Standards as legislated for by national government
 - ii. Standards as devised by local or regional government authorities
 - iii. Standards devised by an independent, non-governemtnal organisation who have been charged with regulating social care.
2. Impact on residents well-being (as measured by either: objective measures such as the Human Development Index or subjective measures), such as:

- Ensuring all of an individual's Activities for Daily Living (ADLs) are met
 - Interpersonal functioning
 - i. Care home community participation and involvement
 - ii. Daily activity
 - iii. Peer relationships
 - Behavioural outcomes
 - i. Behaviour problems as measured by carers reports and any (standardised) measures
3. Improvements in the lives/ conditions of care providers'
 - Morale
 - Employment retention and measurement of employment vacancies
 4. Cost effectiveness
 - Improving cost effectiveness to increase the sustainability of caring
 - Identifying if costs are prohibitive to the extent that they discourage individuals from seeking care services they require

Objective B (Process question)

A range of process measures will be identified and analysed where appropriate. These may include:

1. User experiences
2. Providers' experience
3. Inspectors' experience

Examining for example:

- Perception of the efficacy of inspection at improving outcomes
- In what instances do these group(s) identify inspection as being most effective
- What do stakeholders think about the inspection process

Search Strategy

Reports will be identified from the following sources:

- Bibliographic databases
- Hand searching of key journals
- Reference list of key papers

- Direct requests to key organisations
- Key websites

Electronic searches will be conducted across a range of bibliographic databases for national and international research published since 1991. Websites and requests to key organisations will be used to find relevant research that has not been published in peer review journals.

Bibliographic databases that will be searched are:

UK

- Ageline via CSA Illumina
- Applied Social Sciences Index and Abstracts (ASSIA)
- CommunityWISE
- PAIS International (Public Affairs Information Service)
- HMIC (Health Management Information Consortium)
- Sociological Abstracts
- Social Services Abstracts
- Social Work Abstracts via Ovid
- Social Policy and Practice
- Social Care Online

which includes:

- CareData
- *ELSC (Electronic Library for Social Care)*
- Zetoc
- EPPI-Centre
- TRIP (Turning Research Into Practice) Database

International Databases

- International Bibliography of the Social Sciences
- PSYCinfo
- PubMed
- Web of Science

- Abstracts in Social Gerontology – via CSA Illumina
- Econlit via Ovid
- SOSIG: Social Welfare

US

- CINAHL (Cumulative Index to Nursing and Allied Health Literature) via Ovid

Websites to search

- ESRC
- Centre for Evidence Based Social Services (CEBSS)
- SOSIG: social welfare
- HERO

Grey Literature

- SIGLE, European grey literature since 1980.
- Information for Practice (NYU website on international grey literature)

Hand searching of Key Journals

Restricted to recent issues (those published up to 18 months prior to the beginning of review) of key journals because there may be delay in them reaching electronic databases. Relevant journals will be identified by using the results from my databases search to find the most frequently sourced journals.

Reference list search of all included articles

The reference lists of all studies included in the review will be hand searched to determine if anything relevant has been missed in the database search. Any titles deemed relevant will then be subject to examination of the full text and included if they meet the criteria.

Contacting relevant support and expert organisations

The following organisations will be contacted either via email or letter for advice on any research they know of which is relevant to the question or other organisations or experts which they think may be able to help:

Age Concern England
Care Directions
Carers UK
Care and Health
Community Care
Demos
Help the Aged
IPPR
Kings Fund
Joseph Rowntree Foundation
NCVO
Prime Ministers Strategy Unit
Office of the Deputy Prime Minister
SCIE
Social Market Foundation
Australian Association of Social Workers
Canadian Association of Social Workers
International Federation of Social Workers
National Association for Social Workers (USA)

Search strategy

There is much advice in the literature (see Higgins and Green 2006; Petticrew and Roberts 2006) about how to develop a search strategy. Once I have identified the main concepts and terms in your question there are a few checks to which you need to subject the strategy. First, identify synonyms and related terms (e.g. older, aged, elderly etc) to cover for all possible terms that could lead to a paper relevant to your review. Second, it is important to take account of plurals. Third, it is always helpful to use truncation, if the search engine will allow. Truncation is a function that allows the shortening of a word to be suffixed with an asterisk (*) that signals to the search engine to also look for all other words that can be constructed from the first few letters of the word used (e.g. abus* gives abuse, abusing, abused). This is a very helpful technique because it allows the use of one search term instead of many variations, saving time. Forth, it is extremely helpful to consult a thesaurus for each key search term in order to ensure all possible variations of the term are included. However, it is important to consider these variations carefully because

they have the potential to be counter productive if they force the term to be more general than is appropriate; for example to use the term age on it's own, even within a Boolean search would throw up so many irrelevant outputs it would be erroneous to use. Finally, some database will allow you to search via subject headings, which obviously localises your search and narrows down the possible output (e.g. from getting lots of medical papers when search around older persons care, if you only search under social care). However, it is necessary to be aware that by limiting the search to specific subject areas you may miss relevant papers produced in other domains.

The searches of each database and journal will be conducted using the following strategy and technique.

Facets of question being answered:

Population: Older people in (non-nursing) residential care

Intervention: Effectiveness of inspection and regulation

Cost effectiveness of inspection

Impact of inspection on all stakeholders in residential care

Outcome: Improvement in peoples lives

Study Design: A. RCTs, CTs, CBA, ITS

B. Studies which examine the conditions in which inspection is more or less effective and fulfil inclusion criteria stipulations, will be included in the review

In order to maximise sensitivity I will omit the study design facet from the search strategy because the range of study designs (for effectiveness and process questions) is too broad. Instead the study design will be assessed at the inclusion stage of the review as recommended by the Centre for Research Dissemination at the University of York (CRD 2001).

The databases will be searched using a combination of free text and keyword searchers. Where possible the searchers will be subject to truncation and Boolean techniques in order to increase efficiency and sensitivity of the searching. If these tools are not available for a particular database or search engine then the searching will be conducted manually to ensure appropriate use and combination of all search terms.

Keywords = (“old* people*” or old* or elder* or aged) and (resident* care or resident* or “assist* living” or “retir* home”) and (inspect* or regulat*)

Free-text in title or abstract or full text = (old people/ older people/ elder*/ aged/ very old people) & (inspection/ regulation/ evaluation/ investigation/ assessment) & (resident* home*/ resident*/ home*/ care home/ care*/ support* living)

n.b. * represents truncation command, this will be substituted for appropriate command symbol depending on database being searched.

Methods used in the review

Selection of trials (see Figure 1)

The titles were screened as set out below:

1. First stage of screening will be based on the basis of titles, where studies with an obviously unrelated title will be excluded. However where there is any ambiguity, or the title appears relevant the studies will be taken onto the second stage.
2. Second stage based on assessment abstracts and where available, or the abstract is too ambiguous, on full text.

n.b. SCIE caution that there is a tendency toward over-inclusion at the second stage, so a clear understanding of the review question must be enforced at all times.

As this review is contributing to my PhD thesis I do not have the resources to include a full-time secondary reviewer.

Quality assessment

Objective A

For objective A I have based the study criteria on the Cochrane Effective Practice and Organisation of Care Review Group guidelines (McAuley and Ramsay 2002). To be included in this part of the review the study has to be conducted according to one of the following four designs:

1. Randomised controlled trial (RCT) i.e. a trial in which the participants (or other units) were definitely assigned prospectively to one or two (or more) alternative forms of inspection (or no inspection) using a process of random allocation (e.g. random number generation, coin flips). These alternative forms may include:
 - Inspected home (of certain size, population, staff numbers) compared to non-inspected, control home (of similar size, population, staff numbers).
 - Care home inspected against National Minimum Standards compared to care home inspected based on objective well-being index of residents.

2. Controlled trial (CT) may be a trial in which participants (or other units) were:
 - a) definitely assigned prospectively to one or two (or more) alternative forms of inspection using a quasi-random allocation method (e.g. alternation, date of birth, patient identifier) or;
 - b) possibly assigned prospectively to one or two (or more) alternative forms of inspection using a process of random or quasi-random allocation.

3. Controlled before and after study (CBA) i.e. involvement of intervention and control groups other than by random process, and inclusion of baseline period of assessment of main outcomes. There are two minimum criteria for inclusion of CBAs:
 - a) *Contemporaneous data collection*

Score DONE pre and post intervention periods for study and control sites are the same.

Score NOT CLEAR if it is not clear in the paper, e.g. dates of collection are not mentioned in the text. (N.B. the paper should be discussed with the contact editor for the review before data extraction is undertaken).

Score NOT DONE if data collection was not conducted contemporaneously during pre and post intervention periods for study and control sites.
 - b) *Appropriate choice of control site:*

Studies using second site as controls:

Score DONE if study and control sites are comparable with respect to dominant reimbursement system, level of care, setting of care and academic status.

Score NOT CLEAR if not clear from paper whether study and control sites are comparable. (N.B. the paper should be discussed with the contact editor for the review before data extraction is undertaken).

Score NOT DONE if study and control sites are not comparable.

4. Interrupted time series (ITS) i.e. a change in trend attributable to the intervention. There are two minimum criteria for inclusion of ITS designs in as recommended by EPOC:

a) *Clearly defined point in time when the intervention occurred.*

Score DONE if reported that intervention occurred at a clearly defined point in time.

Score NOT CLEAR if not reported in the paper (will be treated as NOT DONE if information cannot be obtained from the authors).

Score NOT DONE if reported that intervention did not occur at a clearly defined point in time.

b) *At least two data points before and two after the intervention.*

Score DONE if 2 or more data points before and 2 or more data points recorded after the intervention.

Score NOT CLEAR if not specified in paper e.g. number of discrete data points not mentioned in text or tables (will be treated as NOT DONE if information cannot be obtained from the authors).

Score NOT DONE if less than 2 data points recorded before and 2 data points recorded after intervention.

If the study is not any of the above designs, it will not be included in this review. If the study scored NOT DONE for any of the above criteria within each design, the study will not be included. If the reviewer is unsure of the study design, the paper will be discussed with the contact editor of the study before data extraction is undertaken.

Objective B - Assessing quality of studies for the process question(s)

There are currently no established methods for assessing the quality of process evaluations (Kavanagh, Harden et al. 2005). The Evidence for policy and Practice Information and Coordinating Centre (EPPI-Centre) has published numerous reviews which assess the quality of process focused research. I will use criteria developed in previous EPPI-Centre reviews

to assess the quality of qualitative and other types of studies assessing interventions processes and people's perspectives and experiences (Harden et al., 2004; Rees et al., 2004; Thomas et al., 2003; Harden et al., 2001). Studies will be assessed using criteria developed by Kavanagh, Harden et al (2005), according to whether:

- (i) The aims and objectives were clearly reported;
- (ii) There was an adequate description of the context in which the research was carried out (including a rationale for why the study was undertaken);
- (iii) There was an adequate description of the sample used and the methods for how the sample was identified and recruited;
- (iv) There was an adequate description of the methods used to collect data; and
- (v) There was adequate description of the methods used to analyse data.

A final judgement about the quality of objective B studies will relate to the appropriateness of the study methods for ensuring that findings reflect key contextual and process issues. This judgement will be informed by previous EPPI-Centre work in this area and the work of other groups on assessing the quality of process evaluations (cf. Arai et al., 2002; Harden et al., 2001).

Consultation

I will consult with both Information and Knowledge Management and the Service User and Public Involvement Directorate to consult CSCI on the relevance and potential use of this review.

Data management, extraction and synthesis process

Extraction of data from studies searched in this review will follow the following protocol:

- 1. Databases, websites, key journals, reference lists from key papers will be searched and requests to organisations made to begin the inclusion process (see figure 1)**
- 2. Basic data extracted from each search will be added to a 'list of references' (see figure 2).**
- 3. Data extracted from those studies which were deemed relevant enough to obtain the full record, but were then excluded will be added to a 'Table of excluded studies' (figure 3.), which will include a reason for their omission.**

Papers which meet the inclusion criteria will be added to an Excel spreadsheet (figure 4), to provide a map of included literature:

- a. A copy of the data recording and quality appraisal format will be given as part of the review appendix (figure 4)

4. Organise studies in relation to study quality

Once articles have been deemed to fulfil the inclusion criteria. The studies will be assessed for quality. Both information on, and assessment of, the study's quality will be reported under one heading in order to maintain a simple and coherent report presentation. Assessment of the studies quality will be reported along with analysis to give a transparent account of the limitations of included studies.

5. Analysis and synthesis

Analysis of included studies will be presented as follows:

- **Objective A**

Analysis of studies will explore relationships and differences between the study findings, and the extent to which they reflect common, higher order, themes. Interventions will be examined to identify any patterns according to effectiveness. For example are there any common characteristics of inspection which can be judged to be effective or ineffective?

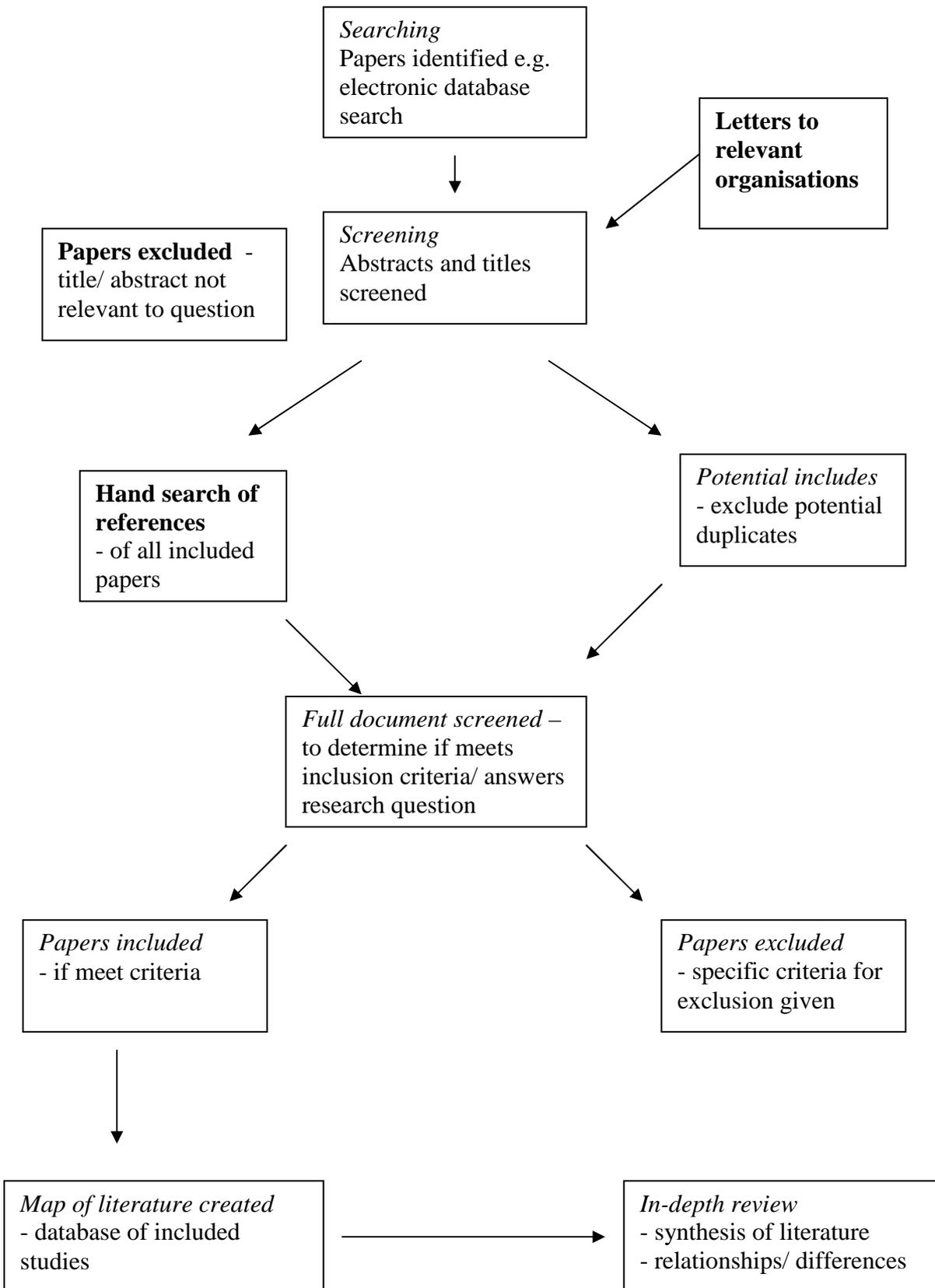
- **Objective B**

For the process questions I will conduct narrative syntheses of the findings from qualitative research and other types of process evaluations. This will help generate hypotheses about what conditions make inspection more or less effective.

- **Cross-study synthesis**

I will combine objectives A and B in a cross-study synthesis order to determine the effectiveness of inspection and make recommendations about the conditions in which they may be most effective.

Filtering of papers from searching to synthesis



APPENDIX 2: LIST OF DATABASES SEARCHED FOR SYSTEMATIC REVIEW

Review Topic: Impact of Inspection on older peoples' residential care

Searcher: M. Norton

Date: 05/04/06

| Database | Dates Covered | Dates searched | Titles/ abstracts | Full Record | Included | Excluded |
|---|---------------|----------------|-------------------|-------------|----------|----------|
| CSA Illumina – Social Services Abstracts Sociological Abstracts ASSIA ERIC | 1991 - 2006 | 05/04/06 | 142 (key word) | 21 | 2 | 18 |
| Ovid – Journals@Ovid CINAHL HMIC IBSS EMBASE Ovid Medline psycINFO | 1991 - 2006 | 28/04/06 | 969 (key word) | 6 | 1 | 5 |
| Social Care Online Incl. AgeInfo | 1991 - 2006 | 06/04/2006 | 280 | 5 | 1 | 4 |
| EPPI-centre | - 2006 | 06/04/06 | 0 | 0 | 0 | 0 |
| Zetoc* | 1993- | 06/04/06 | 1867 | 18 | 0 | 18 |

| | | | | | | |
|---|---------------|------------------------|------|----|---|---|
| EconLit via WebSPIRS | 1969 - 2006 | 07/04/06 | 453 | 2 | 0 | 2 |
| PAIS International via WebSPIRS | 1972 - 2006 | 07/04/06 | 118 | 6 | 0 | 6 |
| SIGLE via WebSPIRS | 1980- 03/2005 | 07/04/06 | 203 | 1 | 0 | 1 |
| Social Policy and Practice via WebSPIRS | - 2006 | 07/04/06 | 1238 | 10 | 2 | 8 |
| ESRC | - 2006 | 10//04/06 | 1578 | 0 | 0 | 0 |
| HERO | - 2006 | 10/04/06 | 0 | 0 | 0 | 0 |
| Social Work Alliance | 1999 - 2006 | 12/04/06 | 560 | 0 | 0 | 0 |
| CommunityWISE | -2006 | 24/04/06 – 25/04/06 | 1350 | 4 | 0 | 0 |
| PubMed Central | -2006 | 01/04/06 – 02/04/06 | 1591 | 2 | 0 | 0 |
| Research in Practice for Adults | - 2006 | 02/04/06 | 62 | 0 | 0 | 0 |
| Turning Research into Practice (TRIP) | | | 18 | 0 | 0 | 0 |

| | | | | | | |
|--|---------------------------------|----------|-------|----|---|---|
| National Citizens Coalition for Nursing Home Reform (website) | All 'professional publications' | 4/05/06 | 40 | 0 | 0 | 0 |
| Information for Practice | | | | | | |
| SOSIG | - 2006 | 5/05/06 | 3 | 0 | 0 | 0 |
| Web of Science | 1991-2006 | 9/05/06 | 188 | 3 | 0 | 4 |
| UrbaDoc - Acompline Urbaline (Greater London Authority Database) | 1991- 2006 | 11/05/06 | | 1 | 0 | 1 |
| TOTAL | | | 12386 | 78 | 9 | |

* Comprises a combination of free text searches that mirror the advanced search strategy when combined. Zetoc does not allow complex searches. n.b. total hits includes duplicates, which may occur between individual searches

Total: 12386 articles; 78 were retrieved and the full text was examined, of these 7 were included in the analysis.

APPENDIX 3: LIST OF ARTICLES INCLUDED IN THE SYSTEMATIC REVIEW

| Author | Title | Date Published | Publication | Database / web portal |
|------------------------------------|--|----------------|--|----------------------------|
| Sinclair, I. and Gibbs, I. | Consistency: a pre-requisite for inspecting old people's homes? | 1992 | British Journal of Social Work | CSA illumnia |
| Sinclair, I. and Gibbs, I. | Residential Care for Elderly People: The correlates of Quality | 1992 | Ageing and Society | Social Policy and Practice |
| Fleishman, R. et al | Improving the quality of institutional care on urinary incontinence among the elderly: a challenge for government regulation | 1999 | International Journal of Health Care Quality Assurance | CSA illumnia |
| Counsel and Care | Under Inspection | 1994 | Counsel and Care report | Ovid |
| Redmayne, S. | Spotlight on Homes for the Elderly: an analysis of inspection reports on care homes for the elderly | 1995 | Bath Social Policy Papers | Social Care Online |
| Day, P. Klein, R. and Redmayne, S. | Why Regulate? Regulating residential Care for elderly people | 1996 | Policy Press and Joseph Rowntree Foundation | Social Policy and Practice |

APPENDIX 4: TABLE OF EXCLUDED STUDIES

| Author | Title | Date Published | Publication | Database/ website/ portal | Why Excluded? |
|----------------------|---|----------------|--------------------------------|---------------------------|--|
| Emslie, S | Rationalising Audit, inspection and review | 2002 | Community Care | Zetoc | <ul style="list-style-type: none"> • Focus on health care • Review of policy • Not empirical research |
| Winchester, R. et al | Best Value: Ahead of the Game | 2002 | Community Care | Zetoc | <ul style="list-style-type: none"> • Summary of Best Value Initiative – a scheme to encourage councils to operate in a more cost-effective manner • Not primary research |
| Walshe, K. | Improvement thorough inspection? | 1999 | Quality in Health Care | Zetoc | <ul style="list-style-type: none"> • Focus on NHS not residential care |
| Wing, H | Older People: Paperwork and Inspection are necessary for the provision of good services | 29/ 10/ 2003 | Community care | Zetoc | <ul style="list-style-type: none"> • Think piece based on anecdotal evidence. • Not empirical research |
| | Inspections can improve quality | 04/ 07/ 2001 | Community Care | Zetoc | <ul style="list-style-type: none"> • Focus on all population groups within residential care |
| | Improvements needed in inspections | 08/ 08/ 2001 | Community Care | Zetoc | <ul style="list-style-type: none"> • Magazine review of social services management policies • No empirical research |
| Cowper, A | An Inspectors call | 2001 | British Journal of Health Care | Zetoc | <ul style="list-style-type: none"> • Focus on health care • Not research |

| | | | | | |
|---|---|------|---------------------------------|-------|--|
| | | | Management | | |
| Nazarko, L | Nursing homes | 1995 | Elderly Care | Zetoc | <ul style="list-style-type: none"> • Focus on nursing care |
| Fujiwara, Y; Hoshi, T; Shinkai, S; Kita, T | Regulatory factors of medical care expenditures for older people in Japan | 2000 | Health Policy | Zetoc | <ul style="list-style-type: none"> • Research on health care costs |
| Bennett, A | Inspector nurse | 1999 | Elderly Care | Zetoc | <ul style="list-style-type: none"> • Focus on nursing home • Opinion piece from author |
| Kerrison, S. H. and Pollock, A. M. | Regulating Nursing Homes: Caring for older people in the private sector in England | 2001 | British Medical Journal | Zetoc | <ul style="list-style-type: none"> • Nursing home focus • Review of in situ regulatory framework in UK, not effectiveness of inspection |
| Various – 9 papers | Standards Matter: A conference report on regulating registered residential and nursing homes for older people | 1999 | Centre for Policy on Ageing | Zetoc | <ul style="list-style-type: none"> • Conference on details of new regulation proposals and ways to regulate based on these proposals. Not research on effectiveness or impact of regulation or inspection |
| Edis, A. | Residential Care The regulatory framework: Can It Help or Hinder Your Client? | 1998 | Elderly Client Advisor | Zetoc | <ul style="list-style-type: none"> • Analysis of UK policy history, not of impact or effectiveness of regulation |
| Rantz, M. J. et al | Assessing Quality of Nursing Home Care: The Foundation for | 1996 | Journal of Nursing Care Quality | Zetoc | <ul style="list-style-type: none"> • Assessing the quality of nursing homes not the |

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|-------------------------|--|------|--|---------------|--|
| | Improving Resident Outcomes | | | | effectiveness or impact of inspection <ul style="list-style-type: none"> • Only single point data collection |
| Fleishman, R. | A Regulatory Approach to Improving Long-Term and Residential Care | 1996 | Quality Management in Health Care | Zetoc | <ul style="list-style-type: none"> • Study of provision and quality of care, not the effectiveness or impact of regulation |
| Gay, E. G. et al | A Comparison of the Effect of Regulation on Health Care for the Older American: A Tale of Two States | 1994 | The Gerontologist | Zetoc | <ul style="list-style-type: none"> • Health care focus |
| Bland, R. | User-centred Performance Indicators for Inspection of Community Care | 1997 | Public Policy and Social Welfare | Zetoc | <ul style="list-style-type: none"> • Focus on community care – inspection of services which facilitate the service user staying in their own home |
| Arai, Y. | Quality of Care in Private Nursing Homes | 1993 | International Journal of Health Care Quality Assurance | Zetoc | <ul style="list-style-type: none"> • Nursing care focus |
| Francis, J | Raising the Quality of Home Care | | | CommunityWISE | <ul style="list-style-type: none"> • Focus on home care not residential care |
| Boyle, G | Facilitating choice and control for older people | | | CommunityWISE | <ul style="list-style-type: none"> • Focus on domiciliary care |
| Francis, J. and Netten, | Raising the Quality of Home Care: A Study of Service Users' | 2004 | Social Policy and Administration | CommunityWISE | <ul style="list-style-type: none"> • Focus on home care • Users' views on quality |

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|--------------------------|---|------|------------------------------------|---------------|---|
| A. | Views | | | | not process or effectiveness of inspection |
| Allen, I et al | Elderly People: Choice, participation and satisfaction | 1992 | Policy Studies Institute report | CommunityWISE | <ul style="list-style-type: none"> • Study of service user choice in social care |
| Doron, I and Lightman, E | Assisted-living for older people in Israel: market control or government regulation? | 2003 | Ageing and Society | CSA illumnia | <ul style="list-style-type: none"> • Discussion paper • Inadequate description of methods |
| Harrington, C. | Regulating nursing homes: Residential nursing facilities in the United States | 2001 | British Medical Journal | CSA illumnia | <ul style="list-style-type: none"> • Nursing home focus • Examines care home performance not inspection performance |
| Braithwaite, J | Regulating nursing homes: The challenge of regulating care for older people in Australia | 2001 | British Medical Journal | CSA illumnia | <ul style="list-style-type: none"> • Focus on quality of homes not effectiveness of regulation • Nursing home focus |
| Nelson, W. H. et al | The Relationship Between Volunteer Long-term Care Ombudsmen and Regulatory Nursing Home Actions | 1995 | The Gerontologist | CSA illumnia | <ul style="list-style-type: none"> • Nursing home focus |
| Alexander, E. R. | Regulation and Evaluation Criteria for housing for the elderly: An International Comparison | 1997 | Journal of Housing for the Elderly | CSA illumnia | <ul style="list-style-type: none"> • Evaluates housing regulations for all types of elderly housing, including non-residential. • Comparison of regulations in various countries – no |

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|--|---|---------|--|--------------|--|--|
| | | | | | | evaluation of their effectiveness |
| Read, J. Klein, B. Cook, G. Stanley, D. | Quality improvement in German and UK care homes | 2003 | International Journal of Health Care Quality Assurance | CSA illumnia | | <ul style="list-style-type: none"> • Examination of quality assurance system for self assessment of quality in care homes • Includes nursing homes |
| Rudder, C and Phillips, C. D. | Citations and Sanctions in the Nursing Home Enforcing System in New York State: The Use and Effects | 1997-98 | Generations | CSA illumnia | | <ul style="list-style-type: none"> • Nursing home focus |
| Wildfire, J. B. et al | The Effect of Regulation on the Quality of Care in Board and Care Homes | 1997-98 | Generations | CSA illumnia | | <ul style="list-style-type: none"> • Looks at the effect of regulation on quality of care, but; • Examines all forms of board an care facilities |
| Mollica, R. L. | Regulation of Assisted Living Facilities: State Policy Trends | 1997-98 | Generations | CSA illumnia | | <ul style="list-style-type: none"> • Summary of policy trends not their effectiveness or impact |
| Greene, A. et al | How do Family Members Define Quality in Assisted Living Facilities? | 1997-98 | Generations | CSA illumnia | | <ul style="list-style-type: none"> • Consultation on what constitutes quality in care, not inspection |
| Edelamn, T. S. | The Politics of Long-Term Care at the Federal Level and Implications for Quality | 1997-98 | Generations | CSA illumnia | | <ul style="list-style-type: none"> • History of Federal regulation policies, no evaluation of their impact or effectiveness |
| Weisskopf, M. | The Good Provider | 1997-98 | Generations | CSA illumnia | | <ul style="list-style-type: none"> • Opinion piece • No primary research |
| Freeman, I. | Nursing Home Politics at the | 1997-98 | Generations | CSA illumnia | | <ul style="list-style-type: none"> • Nursing home focus |

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|--|---|---------|--|--------------|---|
| C. | State Level and Implications for Quality: The Minnesota Example | | | | <ul style="list-style-type: none"> • Discussion of regulation policies at the state level, not the impact or effectiveness |
| Zimmerman, D. R. | The power of Information | 1997-98 | Generations | CSA illumnia | <ul style="list-style-type: none"> • Testing a self-assessment quality indicator not effectiveness or impact of inspection |
| Applebaum, R. | Assuring Homecare Quality: A Case Study of Case Strategies | 1997-98 | Generations | CSA illumnia | <ul style="list-style-type: none"> • Focus on home care not residential care |
| Hawes, C et al | The OBRA-87 nursing home regulations and implementation of the Resident Assessment Instrument: effects on process quality | 1997 | Journal of the American Geriatrics Society | CSA illumnia | <ul style="list-style-type: none"> • Assessment of effectiveness and process of regulation BUT focus on nursing homes and medical procedures not residential care. |
| Fleishman, R. Walk, D. Mizrahi, G. Bar-Giora, M. Yuz, F. | Licensing, quality of care and the surveillance process | 1996 | International Journal of Health Care Quality Assurance | CSA illumnia | <ul style="list-style-type: none"> • Assessment of effectiveness and process of regulation BUT focus on nursing homes and medical procedures not residential care. |
| Hauser, J. and Prutz, C. | Programs for the Aged in Sweden and Switzerland | 1998 | Developments in Health Economics vol.7 | Econlit | <ul style="list-style-type: none"> • Examines health and social care programs for the aged, not regulation |

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|---|--|------|---|----------------------------|--|
| Johne, G. | The Assessment and the Regulation of Quality in Long-Term Care | 1996 | Developments in Health Economics vol. 5 | Econlit | <ul style="list-style-type: none"> Examines definitions and methods of implementation but not the impact or effectiveness of regulation |
| Brown, D | Achieving Excellence in Care: Inspection and Standard setting in Homes for Older People | 1996 | Journal Royal Society of Health | Social Policy and Practice | <ul style="list-style-type: none"> Analysis of 1993 changes in standards for older people with mental health disorders, no assessment of impact or effectiveness |
| O’Kell, S. (Joseph Rowntree Foundation) | The impact of legislative change on the independent, residential care sector in The Independent Care Home Sector | 2005 | Joseph Rowntree Foundation | Social Policy and Practice | <ul style="list-style-type: none"> No distinction between impact on nursing and personal care services |
| O’Hagan, G. | Improving Older People’s Services | 2001 | Social Services Inspectorate (department of Health) | Social Policy and Practice | <ul style="list-style-type: none"> Using inspection to determine whether policy has been implemented rather than evaluating whether the regulation is effective or how the impact regulations has effected the service Looks at all types of care services |
| Bainbridge, I. and Ricketts, | Improving Older People’s Services: A overview of | 2003 | Social Services Inspectorate / | Social Policy and Practice | <ul style="list-style-type: none"> Report on quality of service across older |

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|--------------------------|--|------|----------------------------------|------------------------------|---|
| A. | performance | | Department of Health | | <ul style="list-style-type: none"> person's social care Examines improvements/ changes which service providers and local authorities need to make – no assessment of the impact or effectiveness of inspection or changes to regulation Examines NHS and social care |
| Fry, A. | Inspectors under inspection | 1993 | Care of the Elderly | Social policy and Practice | <ul style="list-style-type: none"> Inadequate description of methods Anecdotal discussion about whether social services should be responsible for inspecting their own services |
| Griffiths, M. | Current and Future Challenges in Commissioning Care Services for Older People: Case Study of West Sussex | 2001 | Managing Community Care | Social Policy and Practice | <ul style="list-style-type: none"> Combines data on nursing and residential homes for older people |
| Stein, J. and Brown, H. | Crossing the divide: the role of inspection units in protecting vulnerable adults | 2001 | The Journal; of Adult Protection | Ovid – British Nursing Index | <ul style="list-style-type: none"> Focus on all of adult care, not just older people |
| Bartlett, H. and Burnip, | Quality of Care in nursing homes for older people: | 1998 | Nursing Times Research | Ovid - Health Management | <ul style="list-style-type: none"> Focus on nursing home abuse |

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|--|---|------|---|------------------------|--|
| S. | providers' perspective and priorities | | | Information Consortium | <ul style="list-style-type: none"> • Assessment of regulation relating to abuse but only in nursing homes, not residential care homes |
| Kerrison, S. H. and Pollack, Am M. | Absent voices compromise the effectiveness of nursing home regulation: a critique of regulatory reform in the nursing home industry | 2001 | Health and Social Care in the Community | Ovid | <ul style="list-style-type: none"> • Assessment of regulation but in nursing homes, not residential care homes |
| Social Services Inspectorate: Department of Health | Responding to Residents: A report of inspections of local authority residential care homes for older people | 1995 | Department of Health Report | Ovid - HMIC | <ul style="list-style-type: none"> • National evaluation of residential homes to assess whether the needs of older people are being met – not an evaluation of inspection |
| Read, J. and Cook, G. | Promoting Partnership with older people through quality assurance systems: Issues arising in care homes | 1999 | Nursing Times Research | OVID - HMIC | <ul style="list-style-type: none"> • Examination of quality assurance system for self assessment of quality in care homes • Includes nursing homes |
| Restsinas, J. | Assisted Living: a regulation dilemma | 2005 | State Legislatures | PAIS | <ul style="list-style-type: none"> • Anecdotal, inadequate description of methods |
| Bartlet, H. P. and Phillips, D. R. | Regulating Residential Aged Care Homes in Hong Kong: Issues for the Asia-Pacific Region | 1995 | Asian Journal of Public Administration | PIAS | <ul style="list-style-type: none"> • Explanation of the development of regulation in Hong Kong, but no research into effectiveness or |

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|-----------------------------------|---|------|--|--------------------|---|
| | | | | | impact |
| Emerzian, A. D. J. and Stampp, T. | Nursing Home Reform: Its Legislative History and Economic Impact Upon Nursing Homes | 1993 | Benefits Quarterly | PIAS | <ul style="list-style-type: none"> • Nursing home focus • Single point data collection |
| Freeman, I. | Nursing Home Reform: <i>Fait Accompli</i> or Frontier | 1997 | Journal of Ageing and Social Policy | PIAS | <ul style="list-style-type: none"> • Nursing home focus |
| Gibson, D. | Regulating the Quality of Care in Aged Care (book) | 1998 | Aged Care: Old Policies, New Problems (Cambridge University Press) | PIAS | <ul style="list-style-type: none"> • Nursing home / Private Hospital focus • Discussion of 1987 Australian regulations for inspection of nursing homes – based on findings from The Nursing Home Regulation in Action Project |
| Gazdar, C. and Fean, L. | The cornerstone of care: inspection of care planning for older people overview report | 1997 | Department of Health report | Social Care Online | <ul style="list-style-type: none"> • Assessment of social service departments planning and management of care, not of regulation |
| Hughes, C. M. and Lapane, K. L. | The drive for quality care in US nursing homes in the era of the prospective payment system | 2002 | Drugs and Ageing | Social Care Online | <ul style="list-style-type: none"> • Focus on nursing home and Medicare payment structure |
| Wright, F. | Lay Assessors and Care Home Inspections: Is There a Future? | 2005 | British Journal of Social Work | Social Care Online | <ul style="list-style-type: none"> • Focus on Adult with learning disabilities not older people |
| Netten, A. | Costs of regulating care homes | 1999 | Registered Homes | Social Care | <ul style="list-style-type: none"> • Focus on all of adult |

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|--|--|------|---|--------------------|--|
| Forder, J. and Knight, J. | for adults | | and Services | Online | care, not just residential care for older people |
| Burgner, T. | The Regulation and Inspection of Social Services | 1996 | Department of Health | Social Care Online | <ul style="list-style-type: none"> • Focus on all of adult care, not just residential care for older people |
| Parker, C. Barnes, S. Mckee, K. Morgan, K. Torrington, J. Tregenza, P. | Quality of life and building design in residential and nursing homes for older people | 2004 | Ageing and society | Web of Science | <ul style="list-style-type: none"> • Assessment of quality of life in relation to building design • Not examining regulation or inspection |
| Mi Oh, K and Warnes, A. M. | Care Services for frail older people in South Korea | 2001 | Ageing and Society | Web of Science | <ul style="list-style-type: none"> • Discussion of care service provision, not regulation |
| Stoudemire, A. and Smith, M. D. | OBRA Regulations and the Use of Psychotropic Drugs in Long-Term Care Facilities | 1996 | General Hospital Psychiatry | Web of Science | <ul style="list-style-type: none"> • Looks at clinical regulations of drug administration in nursing facilities |
| Hawes, C. Mor, V. et al | The OBRA-87 nursing home regulations and implementation of the Resident Assessment Instrument | 1997 | Journal of the American Geriatric Society | PubMed | <ul style="list-style-type: none"> • Focus on nursing homes |
| Bernabei, R. Landi, F. et al | Randomised Control Trial of impact of model integrated care and case management for older people living in the community | 1998 | British Medical Journal | PubMed | <ul style="list-style-type: none"> • Trial of interventions for older people receiving community care in their own homes |
| Davies, B. | The Regulation and Deregulation of Social Care, a | 1999 | PhD Thesis, University of | SIGLE | <ul style="list-style-type: none"> • Could not locate full record |

| | | | | | |
|------------|-----------------------|------|----------------|------------------------|---|
| | PhD Thesis | | Birmingham | | |
| George, M. | Conflicting Interests | 1996 | Community Care | Urbadoc ACOMPLINE - | <ul style="list-style-type: none"> • Inadequate explanation of methods • Reports unhappiness of 3 independent care providers regarding the joint role of purchasing and inspecting of local authorities |

APPENDIX 5: ETHICAL APPROVAL DATA CONFIDENTIALITY AND RECORDING ABUSE

Ethical approval

This research was submitted to, and received approval from, the University Research Ethics Committee and the Association of Directors of Adult Social Services Approval panel. The following section builds upon these submissions and discusses the ethical considerations that had to be resolved before the data collection could take place.

Criminal Records Bureau (CRB) check

Although I was not working with children I was working with vulnerable older people and therefore I had a CRB check conducted on behalf of the Commission for Social Care Inspection. This provided participants with a legal document that confirms I have a no criminal record and signifies my appropriateness to work within a social care environment.

Risk to participants

There was very little direct risk to participants as a result of the interviews, I asked for opinions on the service and inspection, and for information about the individuals' day-to-day lives. I was cautious of the participants role as an 'active subject' and acknowledged the possibility that during the course of the interview participants may view certain events, or aspects of their life, in ways which had not occurred before, or be prompted to recall episodes they find distressing; none of the interviews appeared to cause distress and if they had there was a procedure in place for me to immediately cease the interview: If I was told, or had reason to believe, that my question, or line of questioning, was causing distress then I would have immediately stopped the interview and asked the participant if they are prepared to go on. If they were I would also ask whether they would like me to stop the particular question or line of questioning. In the very unlikely situation that participants became distressed by the interview and were upset I would have inform the service manager immediately.

Preventing ostracism

There was a remote possibility that participants could become ostracised by peers or staff for talking to me, especially if they were known to be critical of the service or other people. Therefore, the interviews with service users were conducted on a one-to-one basis and all data was subject to a strict level of confidentiality (see confidentiality and data protection sections – Appendix 5). I also made both the service and its users aware that my research had no impact on the outcome of inspection by CSCI or evaluation by any other third party body. Any judgements I make in the course of this thesis are in response to anonymised data and every effort to prevent the linking of data to any particular individual has been made.

Participation over time

As this is a longitudinal study I interviewed each of the participants at three points in time. I made potential participants aware of this intention at the beginning of the interview and make it clear that they must be prepared to take part in three interviews over a nine-month period. However, they retained the right to withdraw at anytime.

Explanation of purpose to participants

I opened up the interview with a brief explanation of the purpose of my study. I explained that I was looking at the impact of inspection on the care home and hoped to ask them various questions about their day to day life in the home, what they may like and dislike, and what they feel could be made better.

I explained that I was using a semi-structured interview schedule in order to focus the interview, but that this is flexible and I also want to discuss whatever they deem to be important in response to my questioning. Each participant was also given a letter that outlined the study.

Clarity and understanding

I used clear and plain language when addressing my research participants, and avoided using acronyms or ‘insider’ language, which the participant might not have understood. If I

needed to use 'insider' language I made every effort to provide additional explanatory information. For example, when I was discussing care plans with residents I did not presume they knew what the term meant and made sure I took a blank copy along in order to assist in recognition.

Interviewer issues

The interviews were unlikely to cause distress to the interviewee, except if service user participants report instances of abuse. In this case I followed a slightly adapted version of CSCI guidelines '*Reporting instances of abuse*' (see Appendix 5).

Data Confidentiality

I will not disclose the name or personal details of any institution or person and will make every endeavour to prevent the linking of any quotes or references to a specific individual or institution. In the writing of this research all identities, both institutional and individual, are to be anonymous. However, as acknowledged by many researchers before me, it may, in some exceptional cases, be possible for an outsider, by process of deduction to link references within my final report to people or institutions. In this instance I will not corroborate any assumptions, nor under any circumstances divulge sources of data.

Only I, Matthew Jeremy Norton have access to data recordings. No other third party, including the Commission for Social Care Inspection, have access to any raw data. The Commission for Social Care Inspection, as all other 3rd parties, will only have access to the final report, when all data has been completely anonymised.

Written up transcripts are anonymised. The recordings are kept in my office in a locked filing cabinet, to which only I have access. They will be destroyed 6 months after my PhD thesis has been accepted.

Reporting instances of abuse: where I will draw the line

As I was planning on spending time with residents talking about their lives in residential care I decided as part of my ethical committee submission that I would develop a procedure to use if any instances of suspected abuse were divulged to me by a resident or

any other participant. To do this I took the general definition of abuse set out in the Department of Health's *No Secrets (2000)* guidelines:

Table 1. Definition of Abuse

What is Abuse?

- Abuse may consist of a single act or repeated acts and can occur against a single person or, in a service context, to more than one person at a time.
- Abuse may be physical, verbal, sexual or psychological, or may be an act of omission or neglect.
- It includes discriminatory abuse and abuse that occurs when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not or cannot consent.
- It can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.

Source: Department of Health (2000). *No Secrets: Guidance on Developing and Implementing Multi-agency Policies and Procedures to Protect Vulnerable Adults from Abuse* (LAC [2000]7) see www.dh.gov.uk

I then used the guidelines develop a workable set of criteria of abuse and neglect in conjunction with people at CSCI, which I used as guidelines to determine whether or not issues that were raised during my data collection should be reported:

- Privacy and dignity not being respected when care staff support people with personal tasks such as going to the toilet, bathing or eating.
- The right to make decisions that affect people's lives not being respected.
- Health care, nutrition or educational support provided not meeting people's needs.
- Being bullied or abused by other residents and/or care workers, which either goes undetected or is not tackled when noticed.
- Receiving abusive comments or being treated differently (discriminated against) because of one's disability, sexuality, age, gender, culture or ethnicity.
- Being inappropriately sedated or being physically restrained to make life easier for the care worker.
- Being shouted at, slapped or pushed on a regular basis as a means to get people to do what the care worker wants them to do.

If I come across instances of any of these issues I would immediately report this to the inspector responsible for the service, who could then decide whether to take the matter up with the manager of the service, or, depending on the severity of the claim, the appropriate authorities.

APPENDIX 6: PAPERWORK USED TO PROVIDE EVIDENCE OF SERVICE PERFORMANCE AGAINST THE NMS

The paperwork used to evidence service performance against the seven inspection outcome areas:

1. Choice of Home (Standards 1–6)
 - a. Brochure with clear, up to date service information
 - b. Statement of purpose
 - c. Service User guide / other information services e.g. video
 - d. Needs Assessment plus summary (either from social worker or carried out prior to resident moving in by qualified member of staff), which feeds into Care Plan to show home can meet needs
 - e. Contract stating residents rights and responsibilities
2. Health and Personal Care (Standards 7-11)
 - a. Staff training and qualifications to demonstrate person centred approach
 - b. Care plans – person centred, address needs, consistent
 - c. Paperwork for aids and equipment to promote independence are in place, appropriate and up to date
3. Daily Life and Social Activities (Standards 12-15)
 - a. Service user involvement – meeting records
 - b. Activity record
 - c. Menu / meal record / nutritional advice
4. Complaints and Protection (Standards 16-18)
 - a. Complaints procedure – that welcomes complaints / criticism and deals with them effectively
 - b. Full records of past complaints
 - c. Policies and procedures for safeguarding adults – accessible to staff
 - d. Staff training records – Protection of Vulnerable Adults (POVA)
 - e. Policies on restraint
5. Environment (Standards 19-26)
 - a. Infection control policy
 - b. Safety certificates
6. Staffing (Standards 27-30)
 - a. Recruitment procedure (including user involvement)
 - b. Staff rota / contingency plans for absence
 - c. Induction record – exceeding ‘Skills for Care’ guidance
 - d. Staff training (internal / external)
 - e. Supervision / meeting records
7. Management and Administration (Standards 31-38)
 - a. Business plan
 - b. Practice handbook / training manuals
 - c. Clear lines of accountability
 - d. Accident record
 - e. Monitoring (if owned by parent organisation)
 - f. Risk assessments

APPENDIX 7: TABLES OF REQUIREMENTS MADE IN THE REPORTS FOR EACH CASE STUDY SERVICE

Care Home 1: Service reaction to requirements made during Key Inspection April 2007

| Requirements made in report (Direct from report) | Sources of evidence used by the inspector to make the judgment | Action taken by home by 2 nd data collection point | Action taken by home by 3 rd data collection point | Was the issue still outstanding by end of case study? |
|---|--|--|---|---|
| <p>The home must ensure that care plans adequately reflect all of the needs of the individual. New time scale for completion: 31/07/07</p> <p><i>Theme: Care planning</i></p> | <ul style="list-style-type: none"> • Paperwork – Care plans • Interviews with residents, staff, relatives, manager | <p>Little action taken by manager, but he claimed work was ‘in the pipeline’</p> | <p>Claimed improvements have been made but admitted they were slow. In process of bringing in consultant to advise on improving further</p> | <p>Yes</p> |
| <p>The home must ensure that all the documentary evidence pertaining to staff recruitment is held on file as per the requirements of Schedule 2 of the Care Homes Regulations to ensure that residents are protected. The previous</p> | <ul style="list-style-type: none"> • Paperwork – staff records • Interviews with staff, manager | <p>Little action taken by manager, but he claimed work was ‘in the pipeline’</p> | <p>Staff files all updated in line with schedule 2 of Care Home Regulations</p> | <p>No</p> |

| | | | | |
|---|---|--|---|-----------------------------------|
| <p>timescales of June 2005, 31st October 2005 and 28th February 2006 and 28/08/06 and 31/03/07 were not met. New time scale for completion: 31/08/07 <i>Theme: Staff - Recruitment</i></p> <p>Provision must be made for the appointment of an individual to manage the care home. The previous timescale of 31st March 2006 and 31/08/06 and 31/03/07 were not met. New time scale for completion: 31/08/07</p> | <ul style="list-style-type: none"> • Paperwork – management registration, qualifications • Interview with manager | <p>Temporary manager was in the process of applying for registration</p> | <p>Registration still not complete – waiting for ‘fit persons interview’</p> | <p>Yes (but almost addressed)</p> |
| <p><i>Theme: Management</i></p> <p>All staff must be provided with formal supervision to ensure that any training needs are identified. The previous timescales of June 2005, 31st October 2005 and 31st March 2006 were not met. New time scale for completion: 31/08/07</p> <p><i>Theme: Staff - training</i></p> | <ul style="list-style-type: none"> • Paperwork – staff training records, staff development files • Interview with staff and manager | <p>No progress on this issue</p> | <p>A supervision schedule was in place but the manager admitted he was yet to implement a rigorous regime</p> | <p>Yes</p> |

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|--|--|---|--|------------|
| <p>All staff must receive necessary training in safe working practices to ensure that service users and their health and safety are protected and promoted. This relates specifically to the need for staff involved in the preparation of food to be trained in food hygiene. New time scale for completion: 31/07/07</p> <p><i>Theme: Staff - training</i></p> | <ul style="list-style-type: none"> • Paperwork – staff training and personal development records • Interviews with staff and manager • Observation of staff practices | <p>Kitchen staff were enrolled for training course, but had not yet attended</p> | <p>All kitchen staff had received food hygiene training and certificates were on display in office</p> | <p>No</p> |
| <p>The home must develop a process for reviewing and keeping under review the quality of the home's service provision. The previous timescales that have been set have not been met. New time scale for completion: 31/08/07</p> <p><i>Theme: Management</i></p> | <ul style="list-style-type: none"> • Paperwork – quality assurance procedures • Interview with manager | <p>No action on this issue – manager disputed whether he needed to do anything and was especially hesitant to ask health professionals to spend time reviewing the service as he felt they were busy enough</p> | <p>No action on this issue – manager disputed whether he needed to do anything</p> | <p>Yes</p> |

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|--|--|--|--|-----------|
| <p>The home must ensure that all staff receive training appropriate to the work that they are to perform. This relates specifically to the need for all staff to be trained in the administration of medicines. New time scale for completion: 31/08/07</p> <p><i>Theme: Staff – training Medication</i></p> | <ul style="list-style-type: none"> • Paperwork – staff training and personal development records • Interviews with staff and manager • Observation of medication dispensing | <p>Manager was trying to find a course for his staff but was struggling to find a course he thought provided value for money</p> | <p>Staff had all receive medication training</p> | <p>No</p> |
| <p>The home must make provision for providing recreational activities that are suitable to the needs of the service users. The previous timescales set have not been met. New time scale for completion: 31/08/07</p> <p><i>Theme: Care planning</i></p> | <ul style="list-style-type: none"> • Paperwork – activities records, daily records, individual care plans • Interviews with residents • Observation of daily routine and activities | <p>The manager had begun an activity book to encourage staff to do more with residents. Claimed was in process of hiring an activities coordinator</p> | <p>A part-time activities co-ordinator had been employed and residents spoke of their being many more activities and 1:1 chats</p> | <p>No</p> |

CH 2: Service reactions to requirements from inspection report April 2007

| Requirements made in report | Sources of evidence used by the inspector to made the judgment | Action taken by home by 2 nd data collection point | Action taken by home by 3 rd data collection point | Was the issue till outstanding by end of case study? |
|--|--|--|--|--|
| <p>All service users' files must be regularly reviewed and these reviews recorded. New time scale for completion: 30/06/07</p> <p><i>Theme: Care planning</i></p> | <ul style="list-style-type: none"> • Paperwork – Care plans • Interviews – staff, manager, residents | <p>Manager had directed staff to be more punctual with reviews. There was now a 'mini care plan' in each resident's room, so staff could check preferences at a glance</p> | <p>Line Manager admitted that some files were not being reviewed on time. But he was developing a new system to improve this</p> | <p>Yes</p> |
| <p>Medication must not be left unattended and accessible in communal areas. An immediate requirement notice was served. New time scale for completion: 11/04/07</p> <p><i>Theme: Medication</i></p> | <ul style="list-style-type: none"> • Observation of medication dispensing • Paperwork – medication policy, staff medication training • Interviews with staff and manager about service's methods of | <p>Manager claims this was a one off mistake by member of staff and this staff member had been briefed on medication procedure</p> | <p>Medication procedure has been updated and all staff have been briefed on procedures</p> | <p>No</p> |

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|--|---|--|--|-----------|
| <p>Suitable arrangements must be made for the storage, ordering, recording and safe administration of medicines. This is a repeat requirement, previous timescales of 26/07/06 and 31/12/06 not met. New time scale for completion: 30/05/07</p> <p><i>Theme: Medication</i></p> | <p>dispensing medication</p> <ul style="list-style-type: none"> • Observation of medication dispensing • Paperwork – medication policy, staff medication training • Interviews with staff and manager about service’s methods of dispensing meds | <p>Manager had implemented a new policy to ensure all meds were stored in fixed-wall cupboards and not left on the trolley overnight</p> | <p>Medication procedure has been updated and there is a new analysis sheet in each individual file to ensure meds are being dispensed accurately</p> | <p>No</p> |
| <p>The home must ensure that competent staff are on duty at all times in the number that would ensure that service users’ needs are met. (This was a requirement set on the previous inspection with deadline 31/01/07). New time scale for completion: 30/05/07</p> <p><i>Theme: Staff – training / numbers</i></p> | <ul style="list-style-type: none"> • Paperwork – staff records, staff rota, service user needs assessments, risk assessments • Interviews with staff, residents, relatives, manager | <p>Manager claimed that this was only because a member of staff was sick and usually staff levels are appropriate</p> | <p>Line manager claims to do regular calculations to ensure staff to resident ratio is appropriate, using Skills for Care Guidelines</p> | <p>No</p> |

| | | | | |
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| <p>The home must ensure that planned and sufficient number of staff are on duty on each shift. New time scale for completion: 30/05/07</p> <p><i>Theme: Staff - numbers</i></p> | <ul style="list-style-type: none"> • Paperwork – staff records, staff rota, service user needs assessments, risk assessments • Interviews with staff, residents, relatives, manager | <p>Manager claimed that this was only because a member of staff was sick and usually staff levels are appropriate</p> | <p>Line manager claims to do regular calculations to ensure staff to resident ratio is appropriate, using Skills for Care Guidelines</p> | <p>No</p> |
| <p>The home must display a valid and up to date certificate of liability insurance. New time scale for completion: 15/05/07</p> <p><i>Theme: Documentation</i></p> | <ul style="list-style-type: none"> • Paperwork – relevant certificates | <p>The certificate was held by the PCT but a copy is in the process of being sent to the home</p> | <p>Certificate now in home</p> | <p>No</p> |

CH 3: Service reactions to requirements from inspection report May 2007

| Requirements made in report | Sources of evidence used by the inspector to made the judgment | Action taken by home by 2 nd data collection point | Action taken by home by 3 rd data collection point | Was the issue till outstanding by end of case study? |
|--|--|--|---|--|
| <p>The Manager must achieve an NVQ level 4 in care by December 2006. Previous timescale for action of 30/12/06 not met. New time scale for completion: 01/11/07</p> <p><i>Theme: Management</i></p> | <ul style="list-style-type: none"> • Paperwork – manager qualifications • Interview with manager | <p>Manager had not made any progress on joining and NVQ course</p> | <p>Manager enrolled on a course but had yet to complete</p> | <p>Yes</p> |
| <p>The Registered Person must ensure that the competency of staff administering medication is checked on a regular basis in order to ensure safe practice. New time scale for completion: 01/05/07</p> <p><i>Theme: Medication</i></p> | <ul style="list-style-type: none"> • Observation of medication dispensing • Paperwork – medication policy, staff medication training • Interviews with staff and manager about service’s methods of dispensing meds | <p>Claimed all staff had received training, had no plans to do any checks or supervision</p> | <p>Still no action</p> | <p>Yes</p> |
| <p>The Registered Person must plan and</p> | <ul style="list-style-type: none"> • Paperwork – activities | <p>Claims they’ve</p> | <p>No further</p> | <p>Yes</p> |

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| <p>provide suitable activities for those residents who are partially sighted to ensure stimulation is provided. New time scale for completion: 30/06/07</p> <p><i>Theme: Care planning</i></p> | <p>records, daily records, individual care plans</p> <ul style="list-style-type: none"> • Interviews with residents • Observation of daily routine and activities | <p>been trying to develop games that incorporate the blind resident, but the resident in question still felt left out</p> | <p>development and the resident still felt activities were not suitable</p> | |
| <p>The Registered Person must plan a programme of refurbishment in which to replace</p> <ul style="list-style-type: none"> • The worn dining room carpet • The worn bedroom furniture <p>New time scale for completion: 1/08/07</p> <p><i>Theme: Environment</i></p> | <ul style="list-style-type: none"> • Observation of environment | <p>No action taken – claimed to be in process of getting carpet and furniture replaced</p> | <p>No action taken</p> | <p>Yes</p> |
| <p>The homes induction must be updated to include all of the required elements to ensure that staff are appropriately trained. New time scale for completion: 30/06/07</p> <p><i>Theme: Staff - training</i></p> | <ul style="list-style-type: none"> • Paperwork – induction policy, staff training record • Interviews with staff, manager | <p>Manager claimed to be developing a new policy with the help of a manager from another service</p> | <p>Still no new policy in place</p> | <p>Yes</p> |

CH 4: Service reactions to requirements from inspection report May 2007

| Requirements made in report | Sources of evidence used by the inspector to made the judgment | Action taken by home by 2 nd data collection point | Action taken by home by 3 rd data collection point | Was the issue till outstanding by end of case study? |
|---|---|---|---|--|
| <p>The terms and conditions document must contain reference to the charges made for personal transport. New time scale for completion: 31/07/07</p> <p><i>Theme: Documentation</i></p> | <ul style="list-style-type: none"> Paperwork – terms and conditions | <p>The terms and conditions were being rewritten by Head Office, but as of my 2nd visit the home did not have new copy</p> | <p>An updated version of the T&C were now present in the home</p> | <p>No</p> |
| <p>A copy of the report following a Regulation 26 visit must be available within the home. (This is an outstanding requirement from the last inspection). New time scale for completion: 31/07/07</p> <p><i>Theme: Documentation</i></p> | <ul style="list-style-type: none"> Paperwork – Regulation 26 reports filed by parent company | <p>The manager requested all previous Reg 26 surveys and they are now held at the home</p> | <p>Reg 26's were not being completed every month</p> | <p>Yes</p> |
| <p>Bedroom doors must not be kept open</p> | <ul style="list-style-type: none"> Observation of doors | <p>Bedroom doors</p> | <p>Bedroom doors</p> | <p>No</p> |

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| <p>by unauthorised means. Several were held open with wedges and some had not been closed. The home must seek advice from the fire and rescue services with regard to this. New time scale for completion: 11/05/07</p> <p><i>Theme: Environment</i></p> | <p>being propped open</p> <ul style="list-style-type: none"> • Paperwork – risk assessment | <p>were no longer being propped open – this was a cause of distress to some residents. Manager informed me that a fire safety device was to be fitted so doors could be held open and would release in the event of fire.</p> | <p>now fitted with fire safety device</p> | |
| <p>The home must have an electrical wiring certificate. The manager told the inspector that this work was currently underway. A copy of the certificate must be supplied to the CSCI as a matter of urgency. (Regulation 13(4)). New time scale for completion: 11/06/07</p> <p><i>Theme: Documentation</i></p> | <ul style="list-style-type: none"> • Paperwork – certificates | <p>No certificate from head office, but had letter to say its been carried out</p> | <p>Certificate present</p> | <p>No</p> |

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| <p>The certificate with regard to the maintenance of the nurse call system was out of date. This matter requires urgent attention. New time scale for completion: 11/06/07</p> <p><i>Theme: Documentation</i></p> | <ul style="list-style-type: none"> Paperwork - certificates | <p>Nurse call certificate now present</p> | <p>Nurse call certificate now present</p> | <p>No</p> |
|---|--|---|---|-----------|

APPENDIX 8: TABLES OF CHANGES RESIDENTS WOULD LIKE TO SEE AT EACH CASE STUDY SITE

Table: Changes residents would like to see in Care Home 1

| Resident | Changes residents would like to see | Match inspector criticisms? | Changes by 2 nd data collection point | Changes by 3 rd data collection point | Resident satisfied with changes |
|----------|---|---|--|---|---|
| 1 | Resident feels they are neglecting some of his medical needs – they failed to renew his asthma inhaler after it ran out | Yes – inspector made a requirement for better training in medication, but not based on this specific case | The resident and his daughter had spoken to a senior carer (bypassing the manager) and the issue had been resolved | The resident now felt the home were appropriately dealing with his medication needs | Yes |
| | Better food – resident was not happy with the quality of some meals and was resorting to having his daughter bring him evening meals | No – inspector talked to resident about this, but decided that the food provided was adequate (other residents were happy) and resident’s complaint was due to his ‘expensive tastes’ | No change | No change | (Yes) He accepted that it was his ‘expensive taste’ rather than poor food |
| | More staff - resident does not walk so stays in his room and complains he rarely sees staff during the day. | Yes – inspector issued requirement for manager to reassesses | No change | There was now an extra member of staff on duty in the | No – although there was an extra member of |

| | | | | | |
|---|---|---|-----------|---|---|
| | | staffing rations and skills mix | | afternoon (meaning there was now 3 members on duty between 2pm and 4pm) and 4 for the rest of the afternoon | staff on duty in the afternoon the resident had not seen any change |
| | Greater personalisation – resident does not always want a cup of tea mid-morning, but is afraid to refuse one or not drink it in case they stopped bringing them altogether | Yes – inspector issued a requirement for manager to improve care plans with greater personalisation. But not in direct relation to this comment, which the resident did not make to the inspector | No change | No change | No – still not prepared to refuse occasionally and explain his preference |
| 2 | Lack of activities – Resident’s daughter thought the service lacked provision of both physical and mental stimulation for her mother who could no longer verbally communicate with staff | Yes | No change | The home had employed a part-time activities coordinator | Partially |
| | More staff – bearing in mind her mother’s increased dependency and that of other residents the daughter thought there needed to be more staff on duty, especially during the | Yes – inspector issued requirement for manager to reassesses staffing rations and skills mix | No change | There was now an extra member of staff on duty in the afternoon (meaning there was now 3 | Yes – relative had noticed a small improvement in time staff were |

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|--|--|---|------------------------------------|--|---|
| | afternoon between 2pm and 4pm when there was only 2 staff | | | members on duty between 2pm and 4pm) and 4 for the rest of the afternoon | able to spend with her mother |
| | Poor hygiene - The daughter explained that her mother was only allocated 3 continence pads per day and that when she came to visit she often found her wet. This has not changed despite complaints from the residents daughter | No – although issued a general requirement based on care planning, which if resolved should mean residents continence care would be reviewed. | No Change | The daughter reported that her mother was being changed more regularly and thought this was because of the influence of the new supervisor who had recently started. She had still found her wet on a couple of occasions but was much happier with the care | Partially – acknowledge significant improvement but thought it could go further |
| | No specific domestic staff – the daughter does all of her mothers washing because she claims the clothes ‘look like rags’ if done by the staff. She blames it on a lack of specific domestic staff. | No | | | |
| | Poor management – the daughter felt the key problem with the service was the management and his obstinate | Yes | Relative had noticed little change | There had been a marked improvement from the manager and | Yes – although the progress needed to |

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| | nature – she claimed he refused to listen to criticism or requests | | | he was engaging constructively with the daughter. Although she felt improvement was still required | continue |
| 3 | Lack of activities / stimulation – resident claimed there was not much contact with staff and a lack of activities | Yes | Resident claimed she had not noticed much change | Resident said there seemed to be a little bit more being done, like sessions throwing a ball around, but she still felt provision was poor | No |
| | More staff - resident thought there should be more staff because she was often kept waiting in her room for response to her call alarm | Yes | No change | There was now an extra member of staff on duty in the afternoon | Partially – she still complain of waiting but admitted this had reduced |

Table: Changes residents would like to see in Care Home 2

| Resident | Changes residents would like to see | Match inspector criticisms? | Changes by 2 nd data collection point | Changes by 3 rd data collection point | Resident satisfied with changes |
|----------|---|--|--|--|---|
| 1 | More staff – resident felt the home required more staff, especially at night because she often had to wait ‘quite a while’ for a response to her call bell | Yes – requirement for home to review staffing procedure and skills mix of staff | No – manager claimed the requirement issued in the report was a result of staff sickness on the day of inspection, which meant the home had one less member of staff on duty | No – line manager claimed he does regular staff ratio calculations based on Skills for Care guidelines, and the current ratio meets those requirements | No |
| | More flexibility – resident felt she had to go to bed at 8 o’clock because it fit in with the routine of the home and although she felt she could go later ‘if I asked’, but she did not want to upset the homes routine | No - although requirement for regular reviews of residents care plans, which if done thoroughly would involve asking about bedtime routine | No change | No change – resident still going to bed at 8 o’clock, although she did point out she could stay up if she wanted, but that she did not want to ‘make a fuss’ | No – although not concerned enough to raise the issue with management |
| 2 | Lack of inclusion – resident claimed she would like to go to some of the activities the home puts on downstairs, but she is often not asked | No - although requirement for regular reviews of residents care plans, which if | No Change | Resident passed away | Resident passed away |

| | | | | | |
|---|--|---|--|---|-----------------------------|
| | if she would like to be assisted to attend (as she could not walk unaided) | done thoroughly would involve asking about activities | | | |
| | More staff – resident would have liked to spend more time ‘chatting’ with staff | Yes – requirement for home to review staffing procedure and skills mix of staff | No – manager claimed the requirement issued in the report was a result of staff sickness on the day of inspection, which meant the home had one less member of staff on duty | Resident passed away | Resident passed away |
| 3 | More activities / stimulation – resident claimed he was often bored and would like the home to provide more activities. He liked most of the existing activities but wanted to be able to do more | No - although requirement for regular reviews of residents care plans, which if done thoroughly would involve asking about activities | No – resident claims there were no new activities introduced | No – resident claims there is still only a similar amount of activities | No |

Table: Changes residents would like to see in Care Home 3

| Care home | Resident | Changes residents would like to see | Match inspector criticisms? | Changes by 2 nd data collection point | Changes by 3 rd data collection point | Resident satisfied with changes |
|-----------|----------|---|-----------------------------|---|--|---|
| | 1 | More staff on duty – resident felt she often had to wait a while to be taken to the toilet or to be helped out of bed | Yes | No change | No change | No - Still felt there should be more staff, but this was common across every resident |
| | | More activities – resident claimed they only occurred very infrequently | Yes | Yes - resident claimed they are playing bingo and dominos more often, but there had been no new activities introduced | | |
| | 2 | Staff member not treating resident with respect – resident felt that on particular carer was ‘winding me up’ and making her feel uncomfortable | Yes | Yes – resident claimed the manager had spoken to the member of staff and she was now | Yes | Yes |

| | | | | | | |
|--|--|--|---|--|---|----|
| | | | | treating her with greater respect | | |
| | | Dietary restrictions - Resident felt staff were being very strict with her diabetic diet and would not allow the flexibility of an 'occasional treat' | No | No change | No change | No |
| | | More activities for partially sighted – resident felt left out of what little activities are put on because she could not see to join in, e.g. bingo | Yes | No change – manager claimed she was developing activities that include visually impaired residents but had not tried any yet | No change – manager claimed she had found it difficult to develop activities that include the partially sighted residents | No |
| | | Lack of service users involvement – resident felt she was unaware of 'what was going on' and wanted more input into her care | No – resident was concerned about issues pertaining to her pension and weekly allowance, which she had stopped receiving. She was under the impression the manager was helping to sort this out, but felt the communication on this issue was poor. This poor | No | No – the pension issue had still not been resolved and the resident still felt she had a lack of input into her care | No |

| | | | | | | |
|--|---|------|---|--|--|--|
| | | | communication permeated the residents care in general as she felt she should have more input into her diabetes treatment, which she had lived with for 20 years, and here care needs in general | | | |
| | 3 | None | | | | |

Table: Changes residents would like to see in Care Home 4

| Care home 1 | Resident | Changes residents would like to see | Match inspector criticisms? | Changes by 2 nd data collection point | Changes by 3 rd data collection point | Resident satisfied with changes |
|-------------|----------|--|--|--|--|--|
| | 1 | More staff on duty – resident felt she often had to wait a while to be taken to the toilet or to be helped out of bed | Yes | No | No | No - Still felt there should be more staff, but this was common across the case studies |
| | 2 | More staff on duty – resident felt she often had to wait a while after she rang the call alarm | Yes | No | Resident passed away | Resident passed away |
| | 3 | Lack of interaction with staff – resident would have liked more opportunity to talk with staff | No – although a requirement was issued for manager to review staffing levels | No | No | No |
| | | Lack of user consultation – the resident complained that she was often taken down to sit in communal areas without asking her consent, but the resident did not want to complain to staff in case they stopped taking her all together. | No – resident was interview by inspector but did not mention this to her. | No | No | No – but would not mention it to staff and had not been asked as part of care planning process |

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