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Patients deserve better than this

It seems not a day passes without another damning headline about the Care Quality Commission. The furore over allegations that its top officials suppressed a critical internal review of inspections at Furness General Hospital's maternity unit in Morecambe Bay is just the latest in a long line of scandals to hit the troubled regulator.

Gagging orders, cover-ups and incompetence mire its reputation, and the public, understandably, wants answers. Despite spending more than £750,000 in one year on public relations, as this newspaper reported last week, the CQC's reputation is in tatters.

It has had a rocky history almost from the moment it was established in April 2009 to regulate and inspect health and social care services in England. The first chair, Barbara Young, resigned six months into the job after a report detailing poor care at Basildon and Thurrock University Hospitals NHS Trust was leaked to the media. The report suggested that hundreds of people had needlessly died as a result of poor standards, when just a month earlier the CQC had rated the quality of care at the Essex hospital as "good".

Then there was the horrific abuse at Winterbourne View, a residential home for people with learning disabilities, exposed by *Panorama* in May 2011. The following year, Cynthia Bower, the CQC's then chief executive, resigned ahead of a Government report into the abuse, amid criticism that the watchdog was not fit for purpose. A second *Panorama* exposé in April 2012 uncovered endemic neglect and abuse at Ash Court, a residential home for older people: not only had the CQC failed to detect the abuse, but it had ignored concerns raised by staff.

There is clearly some rot at the heart of the organisation, and it is right that those responsible are held to account. Yet we must also look ahead. We could dismantle the CQC and start again, but an organisation to regulate hospitals and care homes must exist in one form or another, and if we don't address the root of the problems, they will simply recur.

Let's start with the 28 standards, set out by the Department of Health, that the CQC is charged with assessing and that are intended to monitor quality and safety of care. In my view, these place too much emphasis on evaluating bureaucracy and paperwork, and not enough on the patients' quality of care. At present, cases of abuse and neglect are obscured by the CQC's preoccupation with ensuring that hospitals are up to date with paperwork and with collecting vast amounts of data on details such as handwashing.

An inspectorate is only as good as the inspection it carries out, and it is the poor quality of inspections that lie at the heart of the CQC's problems. As a result of budgetary cuts, inspectors currently work from home. While this might have saved some money on desk space, it has led to a sense of isolation and a fracturing of the workforce. There are difficulties with monitoring and training staff, who are also less able to discuss their experiences or to feel part of a team. Opportunities for informal discussions among colleagues – vital to developing good practice – have been lost.

The CQC must also look at the quality of its inspectors. As it admitted last week, for people with no clinical experience to carry out inspections is absurd. It is also scandalous that the CQC does not know how many of its inspectors have clinical experience or even what qualifications, clinical or otherwise, they have.

The CQC struggles to recruit the right people. Thanks to its poor reputation, no doctor or nurse that I know of would dream of doing the job, yet clinicians are best placed to detect abuse and would help lift the regulator from its current quagmire of ineptitude.

The best type of inspection team would comprise medically qualified professionals and lay members of the public to provide balance and objectivity. This is similar to the model used by other regulatory bodies, such as Ofsted. But healthcare professionals are rightly fearful of being embroiled in another scandal, and inflexible working patterns make it impossible for an inspector to continue with clinical commitments.

The CQC needs to launch a recruitment drive among healthcare professionals, offering sessional or occasional work to those currently in clinical posts. The opprobrium that this organisation has attracted is deserved; but for the sake of the patients whom it is there to protect, we need to start improving it now.