Understanding Good Leadership in the Context of English Care Home Inspection Reports

# Structured Abstract

## Purpose

As part of their inspection of care homes in England the statutory inspector (the Care Quality Commission) makes a judgement on the quality of the home’s leadership. Their view is critical as it is intended to inform consumer choice and because the statutory nature of inspection means these views hold considerable authority. This study looks at the content of a selection of reports and seeks to determine what the Care Quality Commission understands by the concept of ‘good leadership’.

## Study Design

A purposive sample of recent Care Quality Commission inspection reports was selected and subjected to a qualitative content analysis. Inspections are structured around five main questions. The resulting themes describe areas of focus within the section of reports that feature the question ‘Are they well-led?’.

## Findings

Inspection reports were found to focus on four main themes: safety and quality of care; day to day management of staff; governance and training in the home; and integration and partnership working. In the discussion section, the authors reflect on these themes and suggest that the Care Quality Commission’s view of leadership is rather limited. In particular, whilst an emphasis is placed within the literature and policy on the importance of leadership in delivering change and quality improvement, little attention is paid to this within the leadership section of inspection reports.

## Value

The analysis in this report offers a view of how the inspection regime implements its own guidance and how it assesses leadership. The reports, as public-facing documents, are artefacts of the inspection regime and critical not just as evidence of the practice of inspection but as an influence on care home operations and the choices of care home residents and their families.

## Research Limitations

The authors’ research is based on a small-scale sample of inspection reports – nevertheless, it suggests a number of avenues for further research into the way in which leadership and management capabilities are developed and monitored in the sector.

# Keywords

Care Home; Social Care; Inspection; Leadership; Change Management;

# Background and Context

Health and social care services within England, are delivered within a local healthcare economy, through a range of interconnected organisations each operating with a degree of interdependence (Martin and Rogers, 2004). The health and social care sector faces fragile, uncertain and turbulent times ahead, as care providers continue to close across the country and contracts are being returned to local authorities, due to increasing demands and continuing cuts to funding. At the same time, close attention is being paid to issues of quality, largely through the work of the Care Quality Commission (CQC) acting as both the independent regulator and statutory inspector of services. As part of their inspection of care homes in England the CQC makes a judgement on the quality of the home’s leadership. Their view is critical as it is intended to inform consumer choice and because the statutory nature of inspection means these views hold considerable authority.

As the population of older people continues to grow, so will both the demand for care and the complexity of care required (Age UK, 2018). Care homes also play a vital role in caring for the elderly population with needs stemming from dementia and other diseases associated with ageing, multimorbidities, and frailty (Bowman and Meyer, 2017). The complexity of the services being delivered is increasing, leading Jones and Bennett (2012) to argue that effective leadership is more important than ever acknowledging that the task of leading across complex interdependent systems of care requires highly skilled leaders if it is to be carried out effectively (Fillingham and Weir, 2014).

The CQC has full responsibility for assessing the safety and quality of care, across adult health and social care services in England, including all care homes (Behan *et al.* 2016). They are sponsored by the Department of Health, and accountable to Parliament (National Audit Office, 2017) and have long forecasted that the sustainability of the health and social care sector was ‘approaching a tipping point’. The quality of leadership in a care home forms part of the CQC inspection regime. This study asks, by considering the content of CQC assessments of leadership in its inspection and reporting what the CQC understands by the concept of ‘good leadership’ (CQC, 2018) through an analysis of the content of sections of their inspection reports which address the question “Are they [the service] well-led?”.

A brief literature review follows, clarifying the role of the regulator and setting out the importance of the CQC’s judgement in respect of health and social care provision in England. The second section of the review outlines arguments which stress the importance of good leadership in the sector and which provide a brief overview of relevant debates in leadership literature.

## The Role of the Regulator

Regulations are often the product of scandal and demonstrate an understandable desire to safeguard a growing and vulnerable aging population (Banerjee and Armstrong, 2015). Often, regulatory frameworks are portrayed as a means of protecting the vulnerable, ensuring public confidence (Cornes *et al*., 2007), reinforcing elements valued by the community (Selznick, 1985) or as a way to promote market efficiency or deliver social welfare (Abradi *et al.*, 2018). Critics, such as Power (1999) suggest that the focus on audit and evaluation is driven by political agendas and may, in face, serve to get in the way of operational improvements the result of which might be a “regulatory state” (Wright, 2009) rather than significant improvement in standards.

Walshe (2003) describes the main aims of regulation as assurance, accountability, and improvement. The CQC aims to motivate service providers to improve by demonstrating best practice, and by highlighting examples of what safe, high-quality care looks like (Behan *et al.*, 2016; Crick *et al.*, 2018) and by compelling providers to undertake minimum standards of training through the enforcement of statutory obligations (Rainbird *et al.*, 2011). The CQC has, at least to some extent, been successful: National Audit Office research has shown that CQC regulation has had a positive impact on the sector, by influencing care providers to make improvements (2017) prior to reinspection.

Whilst elements of safe care can be easily measured and agreed upon, the same is perhaps not true of leadership – Moen *et al.*’s (2018) work with senior doctors describes how their perceptions of being a leader were grounded in social constructs rather than abstract measures. The ability of the CQC to shape our understanding of what it means to be a good leader is a function and a foundation of their influence in the sector. Where there is a lack of clear guidance and expectations, the regulator’s role is to step in “by making concrete the interpretation and application of their rules” (Black, 2017, p.288) and therefore to reduce levels of uncertainty (see also Rowson and McSherry, 2018). This function, labelled ‘interpretive control’ by Black (2017) gives the CQC the ability to define the loci of their attention – what they choose to consider and how they assess its value. As Orellana et al (2017) note, the introduction of a new question ‘is it well-led' (in care home inspections) is an indication of a new priority and evidence of their interpretive control. Changes in the use of language, noted by Wilcocks and Wibberley (2015) are not value-free. Rather, they are important and symbolic, reflecting a control over the nature of the discourse (Maunter and Learmonth, 2020) that derives from the interpretive control that they exercise over the sector. As Black notes, we can shine a light on the “anatomy” of authority by throwing some light on “how interpretive control over the norms (rules, standards, principles) that are written is established and exercised” (2017, p.287).

The activities of regulators, including the CQC, have led to improvements in the quality of care provision. Nevertheless, the burdens of reporting, paperwork and of preparing for inspection create additional workload that may take time away from other activities including the delivery of care (Warmington *et al.*, 2014; Banerjee and Armstrong, 2015). This has led to calls for a review of the regulation regime including from the Professional Standards Authority; the regulator of regulators (PSA 2015; Peate, 2016). Given the focus on inspection, and the time and effort that goes into preparing and responding to inspections, it is important that they are effective as measures of quality and as drivers of improvement.

## Leadership in care homes

The sector faces continuous demands to change and to deliver improvements in both efficiency and quality of care. The effectiveness of these change processes is connected to the quality of leadership in the home, suggesting a vital role for leadership development within the sector (Hafford-Letchfield *et al.*, 2007). Other studies draw a similar connection, including that published by the Faculty of Medical Leadership and Management, King’s Fund and the Center for Creative Leadership (Arnit *et al.*, 2015), Smith *et al.* (2018) and West *et al.* (2015). Leadership is often charged with driving change processes: whether by providing a sense of vision and drive (Brooker, 2007) or through visible and participative involvement of senior staff (Øye *et al.*, 2016). Indeed, the ability to delivery successful improvements in the outcomes of care recipients might be seen as a way to assess the quality of the leadership in the setting (Dewar *et al.*, 2019).

Several studies explore the relationship between management and leadership and note that effective *management* is a pre-requisite for delivering many quality enhancements, including more integrated working (Gage *et al.*, 2012), improved organisational culture and care quality (Owen *et al.*, 2012; Tadd *et al.*, 2013; Donoghue and Castle, 2009). A supportive workplace culture is critical given the often stressful nature of the job (Backman *et al*., 2018) and can lead to fewer conflicts amongst employees, stronger relationships between colleagues, more effective use of resources and increased engagement in work processes (Casper *et al.*, 2017).

Previous work on the nature of leadership helps to put our later discussion of the focus of CQC inspection reports into context and some themes are briefly outlined here. Studies that consider the qualities of those in positions of leadership might focus on the personality traits of successful leaders (for example, Anderson, 2006; Judge *et al.*, 2002; and Nelson, 2016); on the behaviours of successful leaders (Yukl, 2012); or on leadership style (Fiedler, 1967; Eagly *et al.*, 2013). In relation to social work, and hence of particular value for this study, is the move towards thinking about leadership in respect of a spectrum of *capabilities* (BASW, no date) rather than a simple, binary, *competence* (Edmonstone, 2011).

Another common theme in the literature is the question of how leaders engage with those that they are leading. The distinction between *transactional* and *transformational* leadership originates with Burns (1978), who contrasted a leadership approach centred around the exchange of reward for compliance (a transaction) with an approach that was built upon a shared understanding of values, purpose or direction and which focuses on changing or transforming the organisation. This distinction, reinforced by work of scholars such as Bass (1997), continues to be discussed, for example by the work of Bohan and Mitchell (2015) with English Clinical Commissioning Groups or Markova (2018) assessing leadership styles in Czech social care. A more recent development in this area is *authentic* leadership (see Walumbwa *et al.*, 2008; Gardner, 2011) which extends the ideas of a transformational style, focusing on an honest and ethical foundation to relationships between leaders and followers.

Lastly, we might look at where leadership occurs in the organisation. Some continue the ‘heroic’ notion which emphasises the role of “the leader” playing a pivotal part in fostering a supportive environment that balances the demands of a regulated workplace with offering staff control over their work (Dewar *et al.*, 2019; Backman *et al.*, 2018; Orellana *et al.*, 2017; Havig *et al.*, 2011). Other studies reject this framing, suggesting that a collective or shared model of leadership is preferable and that the heroic model is rather outdated (Kings Fund, 2011; Shapiro and Rashid, 2011). Both the NHS Healthcare Leadership Model (NHS Leadership Academy, 2013) and the Professional Capabilities Framework from the British Association of Social Work (BASW, no date) emphasise the importance collective responsibility for leadership. In the case of the BASW, for example, expectations in respect to “Professional Leadership” are outlined from point of entry into training right through to strategic social workers (BASW, no date). In Scandinavia, the idea has been taken further through the concept of ‘co-workerism’ (see for example Andersson *et al.,* 2020).

With so much discussion about the nature of leadership and the role that leaders play within organisations it becomes critical to understand what the statutory regulator understands by the idea of being ‘well-led’. Regardless of ‘what’ leadership is, it is clear that the CQC regards it as important. A letter from CQC inspectors published in the British Journal of General Practice (Gray *et al.*, 2019) states “Every practice in special measures has been rated inadequate in ‘well-led’” and “Investing in leadership has consistently been shown to pay off in the ongoing running of a successful organisation.” (no page). Whilst this refers to the CQC’s role in relation to general practice and not care homes, the message is clear: CQC regard leadership as critical in ensuring that care settings run effectively.

# Methods

Reflections on the role of the regulator and the role of leadership in care homes influence the design of this study and reinforce the need to understand the way that the CQC, as statutory regulator, interpret the nature and practice of leadership.

The research is a qualitative content analysis of CQC reports, focusing on the section describing the inspectors’ view of whether the service is well-led. In responding to this prompt, inspectors make use of 4 ‘key lines of enquiry’: 1) How does the service promote a positive culture that is person-centered, open, inclusive, and empowering? 2) How does the service demonstrate good management and leadership? 3) How does the service deliver high-quality care? And 4) How does the service work in partnership with other agencies? (CQC, 2018; Frankova, 2015). CQC reports are presented using the 4 lines of enquiry, with approximately one page of material summarising their findings in each theme. This research design is grounded within the data (Schreirer, 2012) whilst allowing for a sensitivity to the context of the work (Krippendorf, 2004). The resulting interpretation is a work of co-creation between the researcher and the text (Mischler, 1986). It is acknowledged that the resulting conclusions assume a homogeneity and consistency between and amongst inspection teams; the public data does not allow for further analysis of this dynamic, although it would make for an instructive piece of further investigation.

CQC inspection reports form an appropriate data source for this project because they reflect an official view of the standard of leadership within each setting. As publicly available documents they not only offer an assessment of standards but also indicate the context and focus on inspections and how abstract standards may be interpreted in practice. As Mautner and Learmonth suggest, these “discursive constructions…permeate the taken-for-granted assumptions of organisational actors” (2020, p.275), that is, the way that leadership is discussed in these reports shapes our understanding of leadership. This is not just an academic concern though, these reports are also intended to play an important role in shaping the ‘purchase decisions’ of those that are paying for their own care, forming a critical element of the evidence used in making an informed choice about where to seek care.

Purposeful sampling was used to select cases relevant for the research and to make the most effective use of limited resources (Patton, 2002). This project studied a selection of the most recent inspection reports of care homes within a single English county (2016-2018), capturing a range of ratings and focusing only on the question ‘is this service well-led?’. The resulting sample for this research comprised nine care homes with the well-led question rated ‘outstanding’, eleven rated as ‘requires improvement’, and one rated as ‘inadequate’: a total sample size of 21 care homes. For the purposes of this paper, home names have been replaced by unique letters.

Qualitative content analysis offers a systematic way to summarise large amounts of data into a concise and highly organised summary of key points (Erlingsson and Brysiewicz, 2017). Reports were analysed word by word as larger units of analysis such as lines or full paragraphs, may be more difficult to code and essential information may be omitted (Weber, 1990). The preparation phase of inductive content analysis required the data to be organised and for the researchers to obtain a thorough familiarisation with the data, noting initial ideas through unstructured coding. This led to the creation of categories, which naturally emerged from the data as the researchers discussed and considered the results of the unstructured coding. This abstraction (Elo and Kyngäs, 2008) led to a more general understanding of the research topic through the formulation of the categories (Burnard, 1996).

Findings

In accordance with the qualitative content analysis approach the abstraction stage led to the construction of categories which emerge from the data and which reveal common features across the data. The four categories that emerged from the in-depth analysis of the reports were: safe and high-quality care, care staff, governance and training, and integrated working. These are presented below and then discussed in the following section.

## Safe and High-Quality Care

The literature review highlights that leadership within the health and social care sector is commonly assumed to drive improvements in organisational performance (Hafford-Letchfield *et al.*, 2007). Leadership has been described as crucial for outcomes for both residents and staff, and for high-quality care within care homes (Backman *et al.*, 2017).

Homes that are regarded as well-led have managers that are clearly visible within the service. Reports from the homes describe effective leaders providing a hands-on role, acting as role models, and being known by residents and staff within the services. One report stated that “the home was run by an experienced and skilled registered manager who demonstrated they were passionate about ensuring people received the very best care and support.” (Care Home J Inspection Report 2017, p. 15). In a report for a care home rated as inadequate the leaders were disconnected from the running of the care home and that there was ineffective communication between the management.

Darton *et al* (amongst others) highlight the importance of person-centered care to government policy (2012), and it was seen that delivering a culture of person-centered care was another aspect that the CQC focused on in their reports. Almost all the care homes rated as outstanding reported that the services put residents at the heart of their services. The literature review revealed that leadership within care homes can have a positive impact on person-centered care, especially relating to those living with dementia (Brooker, 2007). The reports for the care homes rated outstanding described effective leaders as running services that “enable people to live their lives as they choose” (Care Home Inspection Report A 2017, p. 23). Most of the reports describe the outstandingly led services as running services with open and transparent cultures, with care being delivered by passionate, caring and highly motivated workforces.

## Care Staff

The literature suggests that effective leadership within health care services have a critical role in relation to the culture within the home and are essential for developing optimism, fairness, accountability, altruism, kindness, and support for staff (Arnit *et al.*, 2015). It also provided evidence that care home managers’ leadership role, has a significant impact on staff perceptions of social support and job strain. Backman *et al* (2018) argued that leadership development within the sector is crucial for driving improvements in organisational performance.

Each report included information relating to staffing issues such as rotas, training, and appraisals, and included comments from staff within the care homes. A common theme amongst almost all the care homes was that their staff members spoke of feeling respected and supported at work by staff and approachable management, and this was particularly apparent amongst all the homes rated as outstanding. One staff member stated that management “are very good at thanking you for your hard work and praising us when we do a good job” (Care Home C Inspection Report 2017, p.20). High quality communication between managers and care staff is valued by inspectors: keeping staff up to date with relevant changes, through measures including staff meetings to share ideas and feedback, regular appraisal or performance meetings, and award ceremonies where staff, residents, and family can vote for staff members to receive awards. It was clear that the lack of adequate support, or recognition of staff achievements from care home managers, was assumed by inspectors to lead to low staff morale and high staff turnover within care services and was associated with homes not considered to be ‘well-led’.

Most CQC reports also reported that staff were aware of their roles and responsibilities, and the organisational structure within the service, with some services offering specific training to staff with the aim of embedding the philosophy of the service within the organisational culture. However, many care homes rated as outstanding, were reported as encouraging staff innovation within the services, a feature that was lacking in all the homes rated as requiring improvement or inadequate.

## Governance and Training

All the homes rated as outstanding had robust safety and quality assurance systems in place and managers were fully supported by directors. Several reports praise compliance checks, efficient internal auditing tools, reviews and external auditor visits carried out by outside consultancy firms. These safety and quality assurance systems were reported to cover a broad range of areas such as health and safety, fire checks, audits on care and medicine records, staff training checks, checks to safety and medical equipment, and some had business contingency plans in place. Some of the services had implemented new computer management systems to ensure that all care and staff records were up to date. These systems were also used to ensure that policies and procedures were easily accessible to staff and up to date, and other services had signed up to external organisations to be updated with any changes to legislation. Whilst most of the homes that were rated as requiring improvement had some form of quality assurance systems in place their functions were not enough to identify the shortfalls identified by the CQC during the inspections.

Training was also another aspect that the CQC focused on within their reports but the amount of information contained within reports varied a great deal. It was evident that every home rated as outstanding was reported to be fully supportive of their staff attending training. This supports efforts for continuous improvements and effective responses to residents’ ever-changing needs. One report stated that “People receive care and support from competent staff because the management team encouraged them to develop new skills and ideas.” (Care Home C Inspection Report, 2017, p.20). The majority of the reports for the care homes rated as requiring improvement failed to mention anything at all regarding staff or manager training, within the well-led section of the CQC reports.

The ongoing professional development of managers was also a feature of well-led homes, ensuring currency in care practice and policy and developing leadership and management skills. The literature also suggests that care home managers’ benefit from attending leadership training (Rippon and James, 2015), including competency-based training in the areas of effective communication skills, team-based approaches to care delivery, population health and information technologies (Davis, 2016). Specialist training in the care homes was another aspect that was highlighted within most well-led homes. Some services had enabled staff to undertake specialised training in order to become ‘champions’ in areas such as the end of life care, health and safety safeguarding, rehabilitation, dementia care, and mental health. Champions disseminate information to staff and can offer supervision and guidance to the workforce.

Most well-led homes take part in training partnerships; working in collaboration with a variety of organisations including local hospices, and the regional Rehabilitation Network. The CQC reported that a service had an annual training programme in conjunction with the local university, and an international university, allowing students to visit community and acute facilities in the area, and to discuss and share ideas and best practice.

## Integrated Working

Integrated working, beyond collaboration in training, is a central element of government policy, intended to deliver a high standard of care (European Observatory on Health Systems and Policies, 2012). Many of the reports sampled mentioned some form of integrated working, such as working alongside GPs, the Local Authority, community nurses, community health teams, and local commissioners. Almost all the reports for well-led homes included input from health care professionals and social workers to gather their views on how the services work demonstrating the extent of integrated approaches in these homes.

The best led homes often offer support to other local care homes by sharing knowledge and best practice. The CQC reported that one outstandingly led service was involved in brokerage, signposting other care providers to appropriate training and funding opportunities. They also welcomed other local care home staff to visit them, in order to demonstrate best practice in delivering a high-quality standard of care, so that staff can take the knowledge back to their service.

Integrated working can also include the effective use of volunteers with some care homes regarding their volunteers as a vital part of their services. The literature review revealed that the use of volunteers in care homes can improve the quality of care delivered and can decrease the risk of resident isolation (Dolbear, 2016). It also revealed that volunteers can be beneficial to provide cognitive stimulation to the residents in long term care settings (Van Zon *et al.*, 2016). Reports show how some services had set up volunteer groups, who interact with residents, relatives, staff, and members of the public. One report stated, “we met volunteers during our visit and saw how they spent quality time with people to reduce the risk of social isolation and to share hobbies and interests” (Care Home K Inspection Report 2018, p.18). Most of the homes rated as requiring improvement or inadequate had no mention of any kind of integration with volunteer workers within their services.

# Discussion

This research started with a simple question about the CQC’s ambition to inspect “the leadership, management and governance of the organisation [to] make sure it’s providing high-quality care” (CQC, 2018): does the content of CQC reports give a clear indication of what a ‘well-led’ care home is like? By extension, can we determine what the CQC’s understanding of good leadership is?

The most notable finding in relation is the *lack* of detail and clarity afforded by these reports with regard to most of the discussions in the leadership literature that were outlined above. Although some questions about what constitutes ‘good leadership’ are resolved, or partly resolved, others are left less clear. Where clarity is given it reflects a vision of leadership which feels sparse, offering little clarity for organisations or for those with an interest in supporting improvements to the quality of leadership in this sector. This finding is important given the role of the regulator in shaping and driving the development of the sector.

There is evidence that some leadership behaviours are common across homes that have the most positive judgements including the visibility of senior staff, clear communication, up to date training and integration of working practices with other organisations. It seems clear that being able to provide evidence of certain behaviours is important in securing a positive judgement in this element of the CQC review. However, reports also indicate elements that reference the personality and style of leaders: for example, having demonstrable passion (personality) or seeking to collaborate with other providers (style). Whilst it is clear that the CQC’s vision of good leadership starts with expected behaviours, elements of personality and style are also valued leaving an overall picture which lacks clarity and which might feel outmoded when more recent discussions focus on sets of competences or capabilities.

There is evidence of a more consistent view of leadership in relation to the transactional versus transformational leadership paradigm. The most successful homes are those in which values of safety, person-centredness, communication, and collaboration are evident and whilst the terminology of transformational leadership is not used, homes that have a consistent set of values and in which staff share a sense of purpose and direction are considered to be ‘well-led’ and to provide the best care. This is no surprise given the focus of CQC reports is on elements such as the safety of residents and the overall quality of care – issues which are perhaps better considered as elements of organisational culture rather than discrete sets of behaviours. Nevertheless, this feels somewhat reductive, with no real consideration given to the value and importance of authenticity in these interactions which is surprising given the potential value of transparent, honest, ethical relationships between leaders and followers (see, for example, Aboramadan *et al.*, 2021; Coxen *et al.*, 2016).

A complex picture emerges in relation to the locus of leadership: whether in addressing questions of leadership the CQC are looking at the approach of senior members of staff (that is, those in ‘leadership positions’) or that they understand leadership of the home to be a matter of collective responsibility that is shared amongst all members of staff. In most cases, the evidence suggests that a home that is ‘well-led’ has senior staff that are ensuring the right behaviours amongst staff, or are ensuring that the home is engaging with best practice (for example, person-centred care). However, there is also evidence of expectations for collective responsibility too. One example is the finding that the best performing homes encourage all staff to innovate and take greater ownership of quality. Given the attention being paid to collective responsibility in the NHS, in professional Social Work and through concepts such as ‘co-workerism’ we might expect to see this become a more prominent feature of CQC reports in the future.

Of particular note is the absence of specific content in the ‘well-led’ section of inspection reports concerning change processes within the homes. Several studies reviewed above highlight the connection between the quality of leadership and the effectiveness of change (improvement) processes and yet no mention is made, for example, of care home leaders showing an awareness or understanding of change management principles beyond the most basic idea that better communication will improve morale and reduce staff turnover.

Whilst the analysis undertaken suggests that no clear model of leadership is being used to inform the CQC’s analysis this does not indicate, as perhaps we might expect, that inspections are inconsistent in their approach. Indeed, the findings suggest that the inspectors routinely focus on the same areas within the home. Greater clarity would, though, support efforts to improve the overall quality of leadership in the sector, to encourage those seeking promotion to senior positions, and to support a sense of ownership, engagement and collective responsibility amongst all staff.

# Limitations

This study reports findings from a small-scale investigation of CQC reports. As such, it may be considered a pilot for further work to support the development of leadership and management capabilities in care homes and in the wider health and social care system. Further work is undoubtedly warranted into the planning and organisation of CQC inspections, into the guidance materials and training of inspectors with regard to concerns of leadership and management, and into the way that leadership and management concerns are managed within the inspection regime.

# Conclusions

The inspections and reporting of the Care Quality Commission are an important driver of standards in many healthcare settings. Their views count because the implications of not doing so, and of receiving a poor inspection outcome, are so severe. It follows that those running care homes should demand from these reports a clear message about what is expected. If the CQC is not clear about what it means to be well-led, then homes simply cannot be expected to respond.

The findings from this small study suggest that whilst there is a degree of consistency in the content of reports there is no underpinning framework of leadership which might offer support to managers and owners of care homes. This is not a purely academic concern; a framework would not only help structure the analysis of leadership skills but would offer a way to improve those skills in order to deliver the types of improvements in care quality and safety and to the business operations of the home.

This study also highlights the value of this method for researchers interested in how perceptions of leadership are shaped and influenced by regulators or other commentators. Whilst the specific relationship between the CQC and care homes may not be replicated in other contexts, this study highlights the value and interest of this type of analysis. Also of note, for example, is evidence of whether and how changing discussions in academic or professional literature filter into the content of formal documents such as these reports. In time, evidence of the impact of studies such as West *et al’s* (2015) or of changing professional frameworks may be seen in these records.

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