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Protecting the rights of patients in psychiatric settings: A comparison of the work of the Mental Health Act Commission with the CQC

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Since April 2009, the Care Quality Commission (CQC) has been responsible for regulating standards of health and adult social care in England, as well as monitoring the operation of the Mental Health Act 1983. The latter function was previously performed by the Mental Health Act Commission (MHAC). This article compares the role and functions of both bodies in terms of their ability to provide a legitimate system of regulation and an effective safeguard for psychiatric patients who are deprived of their liberty. This paper is important, as there is very little published data to date on the work of the CQC and its predecessor, the MHAC. It is also necessary to evaluate changes to the regulatory landscape and compare the different regimes, to find out whether it has improved the protection and quality of care for mental health patients. The article concludes that the CQC does have the capacity to monitor detention, enforce standards and improve the quality of patient care, as long as it continues to endorse a commitment to human rights and service user involvement, to preserve the expertise and knowledge of visiting inspectors and to maintain accountability and political independence from the State.

Keywords: Care Quality Commission; Mental Health Act Commission; Mental Health Act 1983; patient rights; monitoring detention; regulating mental health care.

Introduction

* Senior Lecturer in Law, University of Bristol. I am grateful to Dr Oliver Quick and Mat Kinton for reading through an earlier draft of this article and for their helpful comments. Any errors/omissions remain my own. Some of the research for this article was carried out whilst I was on study leave, with the assistance of funding from a British Academy Small Research Grant, in 2011-12.

The Mental Health Act Commission was established alongside the Mental Health Act 1983 (MHA) in England and Wales to monitor, on behalf of the Secretary of State, the operation of the MHA in respect of patients detained in hospital.¹ On 31st March 2009, the MHAC ceased to exist and the Care Quality Commission (CQC) now carries out its functions in England.² The government's rationale for the change was to enhance professional regulation, create an integrated regulator and harmonise standards across health and adult social care. Some would argue, however, that the rationalisation was driven primarily by economic factors and the merger was not without opposition. For example, the former MHAC itself was concerned that the rationalisation could impact negatively on the rights of service users and create an even greater squeeze on limited resources (MHAC 2008: paras. 8.2 and 8.19). This article will compare and contrast the roles, powers and approaches of both bodies and consider to what extent the CQC, as the new health and social care watchdog for England and a single regulator, is able to take on a broader view that relates more closely to the experiences of people who use mental health and care services. This assessment will necessarily entail an examination of the extent to which the activity of the MHAC has been successfully integrated within the CQC.

Significantly, this article will consider the relative effectiveness of each body in the context of our international obligations under the United Nations Optional Protocol to the Convention Against Torture (OPCAT). The UK

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Scotland is governed by its own mental health legislation and there is a similar specialist monitoring body – the Mental Welfare Commission - in place in that jurisdiction. In Ireland, the presence of the Mental Health Commission is designed to 'promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under [the 2001 Mental Health] Act'. S. 33(1) Mental Health Act 2001 (Ireland). On the effectiveness of the Commission in discharging its statutory functions see C Murray, The role of the Mental Health Commission in Irish mental health law: interrogating the effectiveness of the statutory functions of the Commission (2011) *Medico-Legal Journal of Ireland* 93.

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In Wales, the Healthcare Inspectorate has taken over this monitoring role and it has produced two sets of annual reports to date on monitoring the Mental Health Act and the Deprivation of Liberty Safeguards under the Mental Capacity Act 2005, located at www.hiw.org.uk. The Healthcare Inspectorate is also responsible for regulating all health care in Wales.

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government ratified the OPCAT on 10th December 2003 and designated 18 institutions for the National Preventive Mechanism in 2009, including among them the Care Quality Commission for England, the Mental Welfare Commission for Scotland,³ and in Wales, the Healthcare Inspectorate. National Preventive Mechanisms (NPMs) are national bodies that have the mandate to conduct regular visits to places of detention, as well as to make recommendations and observations to the government and relevant authorities to improve the situation of the persons deprived of their liberty. The OPCAT expressly requires that such NPMs be designated by the State parties, and details some of the basic powers and protections necessary for an NPM to be effective. The key elements of that effectiveness are: a blend of appropriate experience and expertise of visiting teams; a regular system of preventive and unannounced visits, and operational and financial independence from the State.⁴ The involvement of service users in inspection arrangements coupled with a focus on protecting human rights are also desirable in this context. Some of these features are also essential components of effective regulation, as identified by Baldwin and Cave (1999). In their view, legitimate regulation requires an investigation into the expertise of the regulatory body, as well as its procedures for ensuring due process and accountability, and the extent to which it achieves its legislative mandate (1999: Chapter 6). This requires an examination of the extent to which the regulator allows affected parties to participate in the regulatory processes and decisions, by involving service users/patients here for example; the extent to which it achieves its published objectives/mandate, and whether there are proper systems of scrutiny

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The Mental Welfare Commission for Scotland monitors the operation of the Mental Health (Care and Treatment) (Scotland) Act 2003 and the welfare parts of the Adults with Incapacity Act 2000. It has a wide remit to investigate the operation of the legislation and conditions in psychiatric settings, in particular to investigate whether a patient is being ill-treated or neglected.

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Several concepts appear in this Article which are fundamental to the National Preventive Mechanism (NPM) – preventive visits; undertaken on a regular basis that form part of an overall system of visits; experts of the NPM should have the required capabilities and professional knowledge and the NPM should have functional independence from the State. See further Articles 18 and 19 of OPCAT. For further discussion of these key elements see E Steinerte, R Murray and J Laing, Monitoring those deprived of their liberty in psychiatric and social care institutions and national practice in the UK (2012) 16(6) *The International Journal of Human Rights* 865-882.

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and accountability in place. These elements will also be explored in the discussion below. However, the CQC's precise *impact* in providing a more effective safeguard is much more difficult to assess, given the recent nature of the changes and the lack of measurable outcomes for regulatory regimes in terms of affecting the behaviour of those subject to regulation. Quick has reviewed the available research on the extent to which regulation impacts on the behaviour of the regulated body and found major gaps in knowledge in terms of precisely *how* this plays out in practice (1999).⁵ Quick's review suggested that this could be caused by the problems in singling out the exact impact that regulation has, given the myriad of other sources of influence on behaviour. Moreover, Huising and Sibley's research suggests that '*factors internal to the organisation, not legislative or regulatory design, influence the dynamics of compliance*' (2011). The key message from Quick's review of the literature, however, is that regulation '*is far more likely to be complied with when accepted as legitimate by practitioners*' (1999:3). Arguably therefore, the perception of the CQC by the regulated sector i.e. those who work in the health and social care field will be a significant factor in terms of the influence it is able to exert on securing improvements in the standards of care in the sector.

The Mental Health Act Commission (MHAC)

The MHAC was established under the Mental Health Act 1983. Its work involved the deployment of independent Commissioners to carry out frequent, short-notice and often unannounced visits to all National Health Service (NHS) and independent hospitals and care homes in England and Wales where patients may be detained, to check the legality of detention and to interview patients in private to ascertain whether they were being treated appropriately and within the law. Commissioners were employed on a part-time basis and came from a variety of relevant professional backgrounds and also included former service users. The

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The key finding to emerge from this review is the lack of systematic knowledge on how professional regulation affects the behaviour of those subject to regulation. The study concluded that this is likely to reflect the difficulties involved in seeking to single out the impact that regulation has on behaviour, given the myriad of other sources of influence. The message to emerge from a number of studies is that regulation is far more likely to be complied with when accepted as legitimate by practitioners.

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MHAC had a number of key functions. The MHA gave the Commission the power to investigate complaints and assist with the production and revision of the accompanying Code of Practice. The MHAC was also charged with producing a biennial report, which was laid before Parliament; this reported on the MHAC's monitoring programme and findings and placed the work of the MHAC under parliamentary scrutiny. The MHAC was not a regulatory body *per se*: its key focus was on the protection of individual patients whose rights are restricted under mental health legislation. However it did comment more generally in its biennial reports on the conditions of care for patients detained in psychiatric settings. The reports also demonstrated a deep concern for human rights principles, which became an important feature of the MHAC's safeguarding work. In 2006, it published a Strategy on Equality and Human Rights, which aimed to promote a rights-based approach throughout every aspect of its work (MHAC 2006). This methodology was commended by the Parliamentary Joint Committee on Human Rights in 2007, which praised the MHAC for adopting a committed and '*systematic approach*' to human rights (HC 378: para. 188).

There is paucity of research on the role of the MHAC and the work of the MHA Commissioners in England and Wales. Nevertheless there is some evidence to suggest that the MHAC was perceived by many as providing an effective safeguard and voice for patients. For example, the Royal College of Psychiatrists, in its response to the Health and Social Care Bill in 2007, commented that:

'[The MHAC's approach] has been instrumental in giving a voice to those who are detained, those who provide care, and those who campaign for better care' (RCP 2007).

And the Mental Health Alliance, a coalition campaign group of 75 voluntary /user organisations and professional groups, commented that:

'The MHAC has played a crucial role in improving compliance with the Mental Health Act and in safeguarding and ensuring the rights and welfare of people detained in hospital under the Act'.⁶

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In terms of making an impact, it is widely accepted that the MHAC commanded respect among the practitioners who worked with the Mental Health Act. However, the MHAC's remedial powers were restricted, as a matter of policy, it generally only investigated complaints when hospital managers had not been able to satisfactorily resolve the issue⁷ and it was unable to award remedies to aggrieved detained patients. Other concerns about the operation of the MHAC during its lifetime related to internal conflicts and an inability to control its finances during the late 1980s, as well as regional variations in visiting practices, ethos and style (Cavadino 1995:60). This led to a more centrally controlled structure and attempts at standardization of visiting methodology from the early 1990s onwards (Cavadino 1995:61-62).

The Care Quality Commission (CQC)

The cornerstone of the CQC's work is the system of registration for health and adult social care that was introduced by the Health and Social Care Act 2008. The CQC seeks to ensure that the care provided by hospitals, dentists, care homes, private ambulances and in people's own homes, meets Government standards of quality and safety. Before the CQC will grant a licence to operate, the providers must show that their services meet the essential standards for quality and safety.⁸ Since 31st March 2009, the Care Quality Commission (CQC) has taken over the monitoring functions of the MHAC.

The CQC adopts a compliance-based approach to its regulatory function, by setting specific performance standards by which health and adult social care providers are judged. ~~There are 28 standards in all, which have been set by the~~

Mental Health Alliance, *Alliance Policies: The Inspectorate* located at www.mentalhealthalliance.org.uk/policy/inspectorate.html.

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Under s. 120(1)(b)(i) of the unamended MHA 1983 any 'general' complaint about a matter that occurred whilst a person was detained had to be a matter that the MHAC felt had not been satisfactorily dealt with by the hospital managers. However, in theory, the MHAC's power to investigate complaints was much broader. Under s. 120(1)(b)(ii), it could investigate any other complaint as to the exercise of powers and duties under the Act, regardless of whether the hospital managers had already tried to deal with it.

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The essential standards are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

~~Government. They demand a certain level of service, and in some cases specify how that service is to be delivered. The CQC focus is primarily on the 16 standards that most directly relate to quality and safety of patient/service user care, some of which explicitly relate to patient rights and dignity. The standards prescribe certain outcomes to be achieved and, at times, the process for achieving them, such as respecting and involving service users in the delivery of services (Outcome 1); ensuring that providers act in accordance with the consent of service users (Outcome 2); ensuring that service users experience care that is effective, safe and appropriate, and which meets their needs and protects their rights (Outcome 4); supporting service users to have adequate nutrition and hydration (Outcome 5); and ensuring that people who use services are protected from abuse, and their human rights are respected and upheld (Outcome 7). Initially, the Government published 28 standards and the CQC focused primarily on the 16 standards that most directly related to quality and safety of patient/service user care. The standards were revised and simplified in 2013 and there are now 5 standards in total, which are monitored by the CQC. The standards prescribe certain outcomes to be achieved and, at times, the process for achieving them, such as respecting and involving service users in the delivery of services (Standard 1), ensuring that service users are safe (Standard 3) and receiving care, treatment and support that meets their needs (Standard 2).-~~

Most importantly, the same standards now apply to *all* care sectors. So mental health care providers must now be registered by the CQC and demonstrate that the care that they provide meets the essential standards. The CQC aims to carry out assessments at least once every two years. The assessment is carried out by Compliance Inspectors – generic full-time inspectors employed at the CQC, who check all the relevant information about the provider, and by visiting the service to talk to the people who use it and the staff, to observe how the care is provided and to check the provider's records. Standard setting is a common regulatory response, though it is not without difficulty, and commentators have observed that *'the fairness and transparency of standard-setting processes, as well as the accountability of the standard-setters, are factors that tend to loom large when... legitimacy is under discussion'* (Baldwin and Cave 1999:124).

The functions of the CQC remain the same following the transfer of responsibilities. However its remit is much broader than that of the MHAC. The MHAC was restricted to monitoring patients who were formally detained in hospital under the 1983 Act. As outlined above, however, the CQC regulates both health and social care services and their approach to improving the services spans the different settings in which this care is provided. Those settings include hospitals in the NHS and the independent sector, specialist care services, community services, care homes and some aspects of the criminal justice system, for example prison ‘in-reach’ services. Patients may be deprived of their liberty in any of these settings, as they may be subject to a term of imprisonment, detained under the Deprivation of Liberty Safeguards (DoLS provisions) in the Mental Capacity Act 2005, subject to *de facto* detention or compulsorily detained under domestic mental health legislation. This key change in regulation has the *potential* to impact significantly on the standards of care and the effectiveness of the safeguards for patients in psychiatric and social care institutions. MHA Commissioners (as CQC part-time employees) continue to visit patients detained under the mental health legislation, and generic compliance inspectors are responsible for monitoring patients detained under the Mental Capacity Act 2005 or those who are subject to de facto detention in care homes/hospitals. In theory, the CQC is now well placed to assess whether health and social care organizations ensure that people are supported by an appropriate package of care that spans the different services they use.

The intention is that the joint of arms of the CQC (compliance and mental health inspection) should be able to bolster each other to provide a more effective safeguard. And it is anticipated by some that the broader remit of the CQC (to include all types of mental health patient) could enable more effective scrutiny and follow up of standards, provided the work of both sectors is carefully structured and aligned. As noted by Hale:

‘the quality of patient and resident care should be improved by combining the specific duties to protect individual detained and compulsory patients with strong powers to enforce better standards across the whole field of health and social care’ (2010:223-4).

The extent to which the CQC is in fact able to provide more effective scrutiny and oversight of mental health care and detention will be explored below, with particular reference to the OPCAT requirements and the factors identified by Baldwin and Cave relating to achieving a legitimate system of regulation.

Expertise and Independence

MHA Commissioners have traditionally been drawn from a variety of professional backgrounds, as recommended by the Association for the Prevention of Torture (APT 2006:52), spanning law, psychiatry, psychology, health and social care. This is in line with the requirements of Article 18 of the OPCAT in relation to professional knowledge and expertise of NPM members. The MHAC consisted of approximately 100 Commissioners, comprising *'a notable array of specialist expertise'* (McHale 2003:381) in mental health law and/or services. McHale observed that Commissioners *'provide[d] a largely volunteer workforce of hundreds of individuals across the country who have developed considerable expertise in making non-judicial judgments which are an aid to both patients and local managers'* (2003:381). This was certainly reassuring for patients and ensured that the views of Commissioners were more likely to be respected by those working in mental health and social care. One of the keys to achieving effective regulation and scrutiny is to gain the respect and trust of those working within the regulated sector (Baldwin and Cave 1999:80). It is also important for patients and service users to feel that they can trust individual Commissioners, to enable them to open up and talk about their experiences of mental health detention and care. It is equally important for Commissioners to have the right skills and experience to talk to patients who may be agitated and distressed. As noted by Lord Patel, the former Chairman of the MHAC in 2009, *'Visiting staff will need to be comfortable meeting with mental health patients and service users who on occasions maybe highly disturbed. This is a specialist role and not one for people without adequate training, experience or commitment'* (MHAC 2008:256). Crucially, this expertise and experience has been preserved within the CQC, in line with the OPCAT requirements, as the majority of Commissioners have been retained and continue to carry out their role of inspecting and monitoring patients detained under the MHA.

The CQC is a generic monitoring body, which is the product of a merger of several predecessor commissions – the Commission for Social Care Inspection, the Healthcare Commission and the MHAC. Three quite different organizations have been replaced with one multi-functional organization that licenses and monitors providers across a wide spectrum of health and adult social care. Questions do arise as to whether it is more appropriate for visiting bodies to be specialists or have breadth of expertise. There are concerns that having a national monitoring body which has a broader, more generic remit, such as the CQC, could lead to a *‘dilution of specialist skills and a reduction in the already stretched resources’* (Hale 2010:223). This could already be a problem for some groups of detained patients, as the responsibility for monitoring the Deprivation of Liberty Safeguards in the Mental Capacity Act 2005 currently falls within the remit of generic Compliance Inspectors, who are recruited from a range of diverse backgrounds and professions and may not possess appropriate knowledge or expertise. Based on the experience of the MHAC, it is considered vital for the CQC to ensure that *all* its front-line inspectors (both generic and mental health) continue to bring appropriate skills, experience and expertise to the role, in order to comply with the NPM criteria for capability and professional knowledge/expertise.

Preserving the expertise of the Commissioners, and ensuring appropriate training and skills is also important from the point of view of trying to promote a legitimate system of regulation. As noted by Baldwin and Cave, such knowledge and expertise on the part of the regulator will make it easier for the regulator to make informed choices (1999:80). It also serves to enhance the regulator’s perceived legitimacy amongst the regulated group, in this case, the mental health care sector. Moreover, regulators and inspectors who have first-hand knowledge of the sector are likely to enjoy easier access to the information required to set appropriate rules and standards. As noted by other commentators, this is likely to be more cost-effective (Boyes and Gunn 2007:108). And significantly, this also helps to promote a greater degree of trust and co-operation between the regulator and the regulated sector. However, commentators do caution that close relationships of this nature are more susceptible to regulatory ‘capture’ (Baldwin and Cave 1999:36), which occurs when the regulatory body is subject to undue

pressure from the sector and puts the sector's interests ahead of the public at large. This can compromise the regulator's independence and impartiality. The MHAC was particularly susceptible to this as it had no powers of compulsion and was dependent on the co-operation of the sector to provide information and the sector's goodwill to implement its recommendations (Boyes and Gunn 2007:108). However this danger has now been minimized as the CQC does have specific powers to compel health care providers to supply information and remedy deficiencies. But the risk of capture has not been completely eliminated, as the CQC does still depend on the health and adult social care sector to provide it with a lot of information to help it to carry out its function (Baldwin and Cave 1999:36).⁹

Individual MHA Commissioners continue to be independent from the government, judiciary and the authorities responsible for places of detention. The MHAC (and also now the CQC) deployed its Commissioners in such a way as to ensure their independence from the services they visit (MHAC 2008: para. 8.9). For instance, Commissioners employed within the NHS would only be deployed to visit locations and settings outside their own employing Trust/care provider. This minimised the risk of any potential conflict of interest and ensured a degree of impartiality and independence. However, one of the shortcomings of the MHAC was the fact that it was directly accountable to the Secretary of State for Health. The MHAC's activities were '*almost entirely conducted on behalf of the Minister*' and the Minister for Health determined its budget (ss. 120 and 121 Mental Health Act 1983). As acknowledged by the MHAC in its final biennial report, this does not satisfy to the letter the requirements of OPCAT relating to the need for operational and financial independence of the NPM. It also led to criticism from Cavadino who, in 1995, was highly disparaging of the MHAC's confused '*inchoate and hybrid*' status (1995:58). He maintained that it was created in an '*unsystematic manner which left its role, structure and accountability ambiguous*'. Whilst the MHAC was '*allowed and encouraged to*

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As noted by Baldwin and Cave '[t]his gives the regulated [sector] a degree of leverage over regulatory procedures and objectives, a leverage that, over time, produces capture'.

act as if it were independent... ultimately it was on the end of a long rope that could always be hauled in if it was thought to be necessary' (1995:58).

In contrast, the CQC is constitutionally independent as a non-departmental monitoring body at arm's length from the government. In theory, this independence means that the CQC is better placed to provide a critical eye and objective view, in line with the OPCAT requirements. However, in one respect, the functional independence of the CQC is no better than the MHAC.¹⁰ Even though MHA Commissioners are no longer working 'on behalf of' the Secretary of State (s. 52 Health and Social Care Act 2008), section 48 of the Health and Social Care Act 2008 allows the Secretary of State to require the CQC to undertake special reviews or investigations. Several 'special reviews' have been mandated by the Secretary of State in the last few years: Learning Disability hospital services post-Winterbourne; nutrition in elderly services; private clinics after the concerns about breast implants and more recently the Secretary of State instigated a CQC review of abortion clinics. Whilst none of these were explicitly MHA issues, this does mean that CQC resources are, to a degree, still under Ministerial control. On the other hand, Mental Health Act monitoring work is budgeted separately within the CQC, and one would hope that the Secretary of State would be careful not to be seen to interfere in MHA work, unless it was being catastrophically mismanaged. But nevertheless, this still remains a theoretical possibility and a potential problem for OPCAT compliance.

There is however a key difference between the MHAC and CQC powers that could improve the latter's regulatory footprint. The MHAC's role as a regulator of mental health care standards was hampered by its lack of enforcement powers. It could not compel providers to make specific changes and relied heavily on persuasion and the co-operation of mental health care providers to implement its recommendations. As noted by other legal commentators, whilst the MHAC did have a useful '*power to "name and shame" in its published biennial reports presented to Parliament... [the MHAC] was severely limited in its ability to provide justice for detained individuals*' (Boyes and Gunn 2007:111). And some

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I am grateful to one of my mental health law colleagues for highlighting this point.

people were concerned that the MHAC was *'not sufficiently "heavyweight" to give appropriate redress and protection to an exceedingly vulnerable group'* (Boyes and Gunn 2007:111). In contrast to the MHAC, which had teeth but no bite, the CQC, as a national public inspectorate has (in theory) greater resources and the power to impose sanctions on failing institutions and NHS Trusts. Where the CQC is concerned that hospitals and NHS Trusts are failing to meet essential standards of quality and safety, it can impose conditions on registration. For example, West London Mental Health Trust was judged not to be meeting one of these standards, as it did not have a system in place to ensure patients' detention papers were properly renewed under the 1983 Act.¹¹ The CQC also has the power in England to take enforcement action to remove the registration of hospitals and care homes thereby closing down a particular location. The CQC does regularly inspect independent (i.e. privately run) facilities and shut down one of the hospitals operated by Castlebeck Care Ltd at Winterbourne View, Bristol in 2011. Following widespread allegations of abuse, neglect and ill treatment, the CQC inquiry found that Castlebeck Care Ltd had failed to ensure that people living at Winterbourne View were adequately protected from risk, including the risks of unsafe practices by its own staff. Consequently, the CQC took enforcement action to remove the registration of Winterbourne View and the hospital closed in June 2011. Although, significantly, this case also highlights the failure of the system in some cases to adequately protect people with learning disabilities, challenging behaviour and mental health problems, ~~(CQC 2011:12)~~. The shocking conditions at Winterbourne View were uncovered by an undercover BBC journalist, and not by the CQC's own inspections. Protecting this most vulnerable group of patients is surely now a priority for the CQC. The CQC has recognised that it should have been quicker in taking action at Winterbourne View. In response it embarked upon a targeted programme of 150 unannounced inspections of hospitals and care homes that care for people with learning disabilities.¹² More than 100 of these are

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'CQC lifts condition on West London Mental Health NHS Trust' located at: <http://www.cqc.org.uk/newsandevents/pressreleases>.

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See www.cqc.org.uk - Press Release on 4 April 2012. The programme was focused on two outcomes relating to the government's essential standards of quality and safety at that time, looking at whether people experience safe and appropriate care, treatment and support and

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NHS and independent providers that deliver assessment and treatment, rehabilitation and longer term care. The findings of the review suggest a lack of understanding about what safe, person-centred care looks like.¹³ All the services where concerns have been identified must now tell the CQC how and when they will improve. Those failing to meet essential standards could face enforcement action and will face re-inspection if improvements are not made.

Service User Engagement

Visiting members of the former MHAC included users of services, including those who had been detained under the 1983 Act. This is particularly important as former service users can bring the benefits of their own personal experiences at other institutions to their visiting role, as well as building up trust and strong relationships with patients. Under the UN Convention on the Rights of Persons with a Disability (CRPD)¹⁴, for example, State parties are required to ‘closely consult with’ and ‘actively involve’ persons with disabilities in decision-making processes related to them.¹⁵ This, it is argued, can greatly add to the effectiveness of monitoring work as such individuals are ‘experts by experience’ and have a particular role to play during visits, as they may be able to pick up on ill-treatment which may remain invisible to other monitors who have not been ‘through the system’ (MDAC 2010:14). Equally, their presence on the monitoring

whether they are protected from abuse. A final report summarizing the main findings across providers was published in 2012 [and is available on the CQC website](#). The overall conclusion is that leadership and governance needs to be stronger to ensure that services are safe and meet essential standards.

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Ibid. See also www.cqc.org.uk/public/reports-surveys-and-reviews/themed-inspections/review-learning-disability-services.

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The CRPD was adopted on 13th December 2006 and came into force on 3rd May 2008. Some commentators argue that the Convention alters social perceptions by taking a principled approach to disability equality. See further B McSherry and P Weller (Eds.), *Rethinking Rights-based Mental Health Laws* (Hart Publishing 2010)

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team may help to establish trust between the monitor and the patient/resident and could result in reports on visits that are more reflective of the needs of those deprived of their liberty in such institutions (MDAC 2010:15).

The MHAC valued the involvement of service users to the extent that it set up a Service User Reference Panel (SURP) in 2005. The Panel formed part of a wider service user involvement strategy to provide the MHAC with a service user perspective on all aspects of its work, including working alongside Commissioners on visiting activity. The panel was made up of 20-30 people who were, or had been, detained patients, and it brought a unique and powerful perspective to the monitoring and inspection work of the MHAC. Involving patients and service users is a vital step towards understanding the impact of deprivation of liberty and the quality of care in individual settings. A report by the MHAC into the first two years of the Service User Involvement Strategy, including the SURP, found that user involvement had become a regular part of most aspects of MHAC activity. In particular it was making a positive impact in terms of influencing future work programmes, contributing to projects, and direct involvement in the day-to-day practice of visiting Commissioners through joint visits (MHAC 2007). Involving service users directly in visiting activity was shown to assist communication with detained patients and members of the panel were able to provide an independent and user-focused view (MHAC 2008:23). The MHAC made real progress on user involvement and felt strongly that *'it is only by engaging users as the true voice of experience that the effect of detention can be assessed'* (MHAC 2008:264).

The CQC continues to involve service users in the monitoring role in this way ~~-(CQC 2011:12)~~. It tries to focus on the mental health patient's experience by constantly drawing on the feedback and suggestions of the SURP. One of the recent CQC annual reports into the MHA has highlighted the value of the SURP in ensuring that detained patients have a voice. The panel brings a *'unique and expert perspective'* and it is certainly reassuring to know that service user

Article 4 (3)); OHCHR, *Monitoring the Convention on the Rights of Persons with Disabilities. Guidance for human rights monitors*. Professional training series No. 17 (New York and Geneva 2010) p. 33

involvement still forms a routine part of the CQC's MHA monitoring role (CQC 2011b:12). The CQC indicates that service users do still accompany MHA Commissioners on inspection visits.¹⁶ The CQC has also established a Mental Health Improvement Board to advise the CQC on improving outcomes for people who use mental health services and on how the CQC monitors the Mental Health Act. A range of other initiatives has also been introduced to involve service users and the public more broadly in their inspection work. For example, the Experts by Experience programme seeks to involve former service users from a diverse range of backgrounds directly in compliance visits. They take part in the inspection visits and help inspectors write their reports. As acknowledged by the CQC:

'Not only do they bring their own distinctive perspective to the inspection, but their presence also helps people using the service to feel more relaxed and confident about talking about their care' (CQC 2012: Section 3).

Moreover, the CQC is required to publish, after consultation, a Statement on User Involvement. As noted by Prosser, *'this goes much further than the statutory participation requirements of any other regulator'* (2010:133-4) and provides a valuable opportunity for inclusive and reflective regulation. The extent to which regulatory bodies operate transparent and accessible procedures is another key benchmarking factor in assessing whether a particular regulatory system is effective and acceptable (Baldwin and Cave 1999:79). The CQC's commitment to service user involvement is a strong indication of the extent to which its processes are open and accessible, which can have a strong legitimating effect. Provided, of course, that the degree of user participation is meaningful and not purely tokenistic, and does not compromise the overall effectiveness of the CQC's decision-making.

Human Rights Focus

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Located at www.cqc.org.uk/public/what-are-standards/your-rights-under-mental-health-act/what-can-mental-health-act-commissioner-do-for-you.

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The involvement of service users charted above is an indication of how the MHAC put equality and human rights at the forefront of its work. It adopted a strong rights-based approach to regulation, by focusing specifically on the legal safeguards for detained patients and engaging directly with patient rights. The Parliamentary Joint Committee on Human Rights commented in 2007 that *'lessons can be learned from the more systematic approach [to human rights] pioneered by the Mental Health Act Commission'* (HC 378: para. 188). Even greater attention must be paid to the conditions in psychiatric and care homes from a human rights perspective in the light of the recent European Court of Human Rights decision in *Stanev v. Bulgaria*.¹⁷ For the first time, the Court found a violation of Article 3 of the ECHR (prohibition against inhuman and degrading treatment) due to the appalling conditions that Mr Stanev had experienced over a period of seven years in a Bulgarian care home. The Court found that the food was insufficient and of poor quality; the building was inadequately heated in winter; the toilets were in an execrable state and Mr Stanev was only able to shower once a week in a dilapidated bathroom. Even though there was no suggestion that the Bulgarian authorities deliberately intended to treat Mr Stanev in a degrading way, taken as a whole, his living conditions for this period of time amounted to degrading treatment, which clearly violated Article 3 of the ECHR. This is obviously an extreme case, but in light of some of the findings of severe and sustained abuse which occurred at Winterbourne View for example, the CQC should be mindful of the potential Article 3 violations where there is a prolonged period of abuse/ill treatment and persistent poor standards.

The CQC appears keen to adopt a comparable rights-based approach to regulation, which is particularly relevant to those people detained under the MHA. The CQC has been working closely with the Equality and Human Rights Commission to develop joint guidance for inspectors and assessors, to ensure they scrutinize equality and human rights issues when reviewing providers' standards of care. It is heavily focused on the ECHR, though does make some brief

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Application No. 36760/06, Judgment delivered by the Grand Chamber on 17th January 2012.

reference to the United Nations CRPD and the Convention on the Rights of the Child, both of which have been ratified by the UK government. The CQC has designed observational and interview tools to assist inspectors in assessing equality and human rights. It is encouraging to note that human rights and equality issues are intended to underpin the routine day-to-day work of inspectors and assessors.

This rights-based regulation appears to permeate the rhetoric of the CQC. The MHAC reports focused closely on human rights issues and ~~a recent~~ the CQC's most recent generic annual report also recognizes that it is important to embed equality and human rights into their regulatory work (CQC 2012:28). In March 2010, the CQC launched an *Equality and Human Rights Scheme*, which seeks to put equality and human rights at the forefront of all its work and activities. It refers to the need to adhere to the principles in the Human Rights Act 1998 and states that the CQC is aiming to be a '*rights-based organization ...that observes and promotes the core human rights principles of fairness, respect, equality, dignity and autonomy for all*' (CQC 2010a:11). A key element of the scheme is to ensure that care is centered on people's needs and protects their rights. The scheme is also intended to inform and influence the day-to-day work of inspectors and Commissioners, by encouraging them to look at equality and human rights issues in their standards compliance and inspection work. Quality and safety are at the heart of the CQC's essential care standards, and, as noted above, several of the outcomes set by the care standards relate to basic human rights, such as the need to treat people with dignity and respect in Outcome 1.

The CQC's Third Report to Parliament on the *State of Health Care and Adult Social Care in England 2010/11* (HC 1487) indicated that across both health and social care, some action has been taken by providers on race equality, followed by disability equality, religion and belief. However, there are some equality issues that still receive less attention including age, gender, gender reassignment and sexual orientation. Under the NHS Constitution patients have the right to be treated with '*dignity and respect, in accordance with [their] human rights.*' The report suggests that there are still continuing concerns about staff shortages and practices (for example call bells being put out of reach or curtains not being closed properly), which demonstrated a lack of respect for patient

dignity and privacy. (HC 1487:54-55). Moreover, there is very little evidence to suggest that the CQC engages directly with international human rights standards on the ground, nor does it specifically address whether there are breaches of UN Treaties such as [OPCAT](#) or the CRPD. Indeed, so far there has been very little guidance to national monitoring bodies such as the CQC on precisely how some of these international standards translate into practice at a national level (Steinerte, Murray and Laing, 2012). The CQC's first report in 2010 into the operation of the MHA 1983 identified a number of failings, which could breach human rights principles and recommended a number of priority areas for improvement (2010b:23-24). It is therefore disappointing that the CQC's more recent [generic](#) annual reports contain very little specific reference to human rights in health and social care (HC 1487:39). There are also concerns about the adequacy of the training provided to generic compliance inspectors and their lack of awareness of these issues.¹⁸ This is worrying in light of the breadth of services that they are expected to cover. At this stage, therefore, the available evidence would suggest that human rights and equality issues are not necessarily informing the work of the CQC inspectors as significantly as we would hope. ~~Moreover, the CQC's Third Annual report acknowledges that there may be some under reporting of human rights issues, such as dignity initiatives, in NHS Trusts as the work lacks central co ordination and tends to be dispersed and localized (HC 1487:39).~~ So there is still more work to be done to promote and embed patient dignity and [awareness of](#) international human rights within the regulatory work of the CQC.

Inspection and visiting arrangements

MHA Commissioners developed a close relationship between frequent personal meetings with patients and maintaining a high level-monitoring role. The Commission adopted a proactive visiting regime involving routine announced and unannounced visits. For example, in 1999-2001, Commissioners met over 22,000 detained patients (Clayton 2002:101). The MHAC felt strongly that *'regular and frequent visits to providers is the only way to ensure patients' rights are protected, the potential for abuse of patients is minimized, and appropriate care is provided*

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Private communication with CQC-employee, April 2012.

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at all times' (MHAC 2008:264-264). Moreover, in order to be effective, visits must be frequent and regular with the opportunity for unannounced and short notice announcement visits. Patients valued the opportunity to meet with individual Commissioners and speak to them about their experiences of detention and mental health care. Regular unannounced visits are a crucial tool in ensuring that patients' rights are protected and that the potential for abuse is minimized. From a human rights perspective, this approach is clearly in line with several aspects of United Nations requirements for an effective National Preventive Mechanism (NPM) in Part IV of the OPCAT.¹⁹ The value of surprise unannounced visits in helping to drive up standards of care was recognised by the CQC in its *Third Report into the State of Health and Adult Social care in England* (HC 1487). The CQC plans to introduce more unannounced elements to monitoring the care sector in an attempt to improve the regulation of all health and social care standards.

The CQC set out its priorities at the start –for improving the quality and safety of mental health services. These include ensuring that people using mental health services receive care that is safe and promotes their health and wellbeing, as well as receiving care in an environment that promotes respect, choice, involvement and autonomy; informing and involving service users; and promoting equality and diversity (CQC 2009:9-10). In order to continue to provide effective inspection and monitoring and promote the welfare and health of patients, it is vital for the CQC to preserve qualitative input at the same time as quantitative monitoring. The function of meeting patients is seen as essential to provide practical evidence as to whether the legislation is being implemented properly in relation to individual patients and observing more generally the standards and quality of patient care. It is crucial to preserve the practice of proactively visiting hospitals, making unannounced visits and meeting directly with patients. The government's obligations to people who are deprived of their liberty would not be met by reactive visits alone. And as one commentator has noted

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Several concepts appear in this Article which are fundamental to the National Preventive Mechanism (NPM) – preventive visits; undertaken on a regular basis that form part of an overall system of visits; experts of the NPM should have the required capabilities and professional knowledge and the NPM should have functional independence from the State. See further Articles 18 and 19 of OPCAT.

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‘Such meetings are also vital to the well-being of individual patients, who often have no other independent person to whom they can turn for informed advice and help’ (Clayton 2002:103).

The CQC states that it aims to visit every psychiatric ward where patients are detained at no more than eighteen-month intervals and many wards are visited more frequently than this, according to perceived need. The CQC anticipates having approx. 6,000 contacts with patients each year, the majority of which will be unannounced visits (CQC 2010a:25). During 2011/12, the Commissioners carried out 1,546 visits and met with 4,569 patients in private (CQC 2011b).²⁰ It is a concern that the total number of annual patient visits by Commissioners does seem to be declining since the CQC took over. This could be explained by internal tensions, resource constraints or changes to the working patterns of MHA Commissioners in an attempt to harmonise the compliance and inspection visits. It could also be due to the increased workloads and sheer number of providers that the CQC is now expected to regulate. Whatever the cause, it does signal a decline in direct contact with patients and less focus on qualitative data collection, which ~~is worrying as it~~ raises questions about how well the CQC is discharging its monitoring duty under s.120 MHA for detained patients, ~~and~~.

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Accountability, Reporting and Public Scrutiny

The MHAC was required to produce biennial reports that were laid before Parliament. In contrast, the CQC produces an annual report, which is also laid before Parliament, on the exercise of its functions under the MHA (s. 120D MHA 1983). In this way, the work of the CQC (and previously the MHAC) is subject to public examination and parliamentary scrutiny. This is another important benchmarking element that is often used to establish the legitimacy of regulatory bodies. As noted by Baldwin and Cave, regulatory agencies which are accountable in this way to an elected representative body, such as Parliament, claim that *‘this oversight renders its exercise of powers acceptable’* (1999:79).

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Similarly, in 2009/10, the Commissioners met with 5,078 patients, made 1,711 visits to wards, and around 1 in 3 of those visits were unannounced and 9% took place at the weekend – See CQC, *Monitoring the Mental Health Act in 2009/10* (CQC 2010) p. 16.

The MHAC reports were voluminous and authoritative narratives on the operation of the MHA. The reports evolved over time to promote good practice and provide important accounts of the experiences of detained patients and standards of mental health care. As well as commenting specifically on the operation of the mental health legislation with respect to detained patients, the reports would highlight more generally areas of concern about staff shortages, ward conditions and standards of care in psychiatric settings. The biennial reports helped to influence numerous specific improvements in mental health services and compliance with the MHA. In the words of William Bingley:

‘As the years went by, the scope of the reports expanded to include extensive summaries of relevant legal developments, discussion of potential relevant legal and policy development as well as the concerns identified by the everyday visiting activities of Commissioners’ (2011:121)

Repeatedly, the biennial reports found huge variations in the quality of care across inpatient mental health services and disproportionate levels of coercive treatment, particularly experienced by some black and ethnic minority groups. For example, the Twelfth Biennial Report highlighted continuing concerns over ward environments as well as patient dignity and safety (MHAC 2008: para. 2.1). ~~The report contained~~~~There have also been~~ frequent examples of ~~the use of~~ seclusion and restraint being carried out without adherence to the Mental Health Act Code of Practice or the use of appropriate safeguards (MHAC 2008: paras. 2.125-2.135). Consequently, the MHAC reports regularly recommended improvements to staff training, ward conditions and overall changes to the delivery and quality of patient care. One of the main shortcomings of the MHAC however, was that it was not empowered to enforce its recommendations. And the fact that the same concerns were repeatedly highlighted in successive reports suggests that it was not able to exert sufficient influence to bring about wholesale improvements in mental health care. In one sense, the reports were useful as they had the power to ‘name and shame’ offending providers and services, but there was no guarantee that the recommendations would be acted on or implemented.²¹ As discussed above, the

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CQC does have more extensive powers to impose sanctions and impose conditions on registration in an attempt to effect improvements. And there are many examples on the CQC's website where it has exercised these powers to take enforcement action.

So far, the CQC has published three specific mental health monitoring annual reports, which are considerably shorter and far less detailed than those of the MHAC. They certainly do not provide us with a rich source of data and detailed analysis, as the MHAC reports have done previously. Perhaps that is inevitable given the need to produce reports on a more frequent annual basis. However it is lamentable that we have lost the depth and breadth of data and analysis that was present in the Biennial reports, as they were a tremendously useful resource. Rather than provide a detailed overview of the operation of the MHA, the CQC reports published to date have focused on a number of key issues, which have emerged from the recent MHA Commissioner observations and visits. Foremost are concerns about inadequate staffing levels, cultures of control and containment, and over-occupancy of beds. These were repeatedly identified by the MHAC in its biennial reports. Two of the ~~One of the~~ essential standards for registration (~~Outcome 13~~) refers to the need to ensure that patients are safe and cared for by enough properly qualified staff because there are sufficient numbers of the right staff. So the onus is on hospital managers/care providers to demonstrate that the staffing levels are sufficient to protect patients, otherwise the CQC could take enforcement action. Some MHA Commissioners have been concerned about the lack of patient involvement in planning, developing and reviewing their own treatment and care. This is a key strand of outcome 1-one of ~~of~~ the essential standards. Significantly, the CQC has also published its first reports on how the DoLS are being implemented in care homes, hospitals, councils and primary care trusts (CQC 2011c; 2012b). The most notable findings suggest lack of training and awareness among some managers and staff of the

As noted by Lady Hale, 'the MHAC was not always able to produce results', and she cites two such examples, where improvements did not occur at Broadmoor Hospital until others stepped in and how the MHAC failed to uncover the severity of problems subsequently revealed by the Blom-Cooper inquiry at Ashworth Special Hospital (2010: 226).

DoLS provisions. The CQC has pledged to continue to monitor these issues closely.

As well as producing annual reports summarizing its regulatory work, the CQC is well placed to carry out specialist surveys and reports into particular areas of care, such as mental health and maternity services. For example, it conducts an annual community mental health survey that will provide valuable information to assess progress in improving people's experiences of care and support.²² This information can be used to further inform the work of MHA Commissioners and compliance inspectors, as it is important to make the best use of the available sources of data and intelligence.

The CQC has been held to account and its work subject to considerable external scrutiny and review, both in the media, in the mid-Staffordshire NHS Foundation Trust inquiry,²³ and by the National Audit Office (HC 1665) and Parliamentary Health Select Committee in 2011 (HC 1430) and again in 2012 (HC 592). The National Audit Office commented that '*against a background of considerable upheaval, the CQC has had an uphill struggle to carry out its work effectively and has experienced serious difficulties*' (HC 1665:10). And the Parliamentary Health Select Committee was highly critical of the CQC's overly tight timescales and resources, bureaucratic registration process and distorted priorities (HC 1430). Its first report, published in September 2011, highlighted the decline in inspections during the first 6 months of the new regulatory regime and the regulator's 'distortion of priorities' by focusing on '*the essentially administrative task of registration*' at the expense of '*its core function of inspection*' (HC 1430: para. 6). Taken together, the findings indicate that this

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The 2011 survey of people who use community mental health services was completed by over 17,000 people aged 16 and over. The vast majority of participants said they were listened to and had trust in their health and social care workers. However, the findings show there is room for improvement, especially in involving service users more directly in some aspects of their care. See www.cqc.org.uk

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The Mid Staffordshire NHS Foundation Trust Public Inquiry Final Report (February 2013) located at www.midstaffspublicinquiry.com.

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'super' regulator is struggling to manage its workload and meet its new (and expanding) responsibilities.

Integrating mental health monitoring within the CQC

Another crucial element to the success of the CQC's role in monitoring all aspects of mental health detention and care is how the MHA monitoring role links in to the CQC's wider regulatory role. Successful integration and cooperation between the compliance and MHA Commissioner inspection teams is a vital component. One suspects that there have been some teething problems in terms of alignment and joint working during the initial stages, which forced the CQC to review its mental health monitoring programme in 2010 [and again in 2013 \(CQC 2013d:10\)](#). The CQC's MHA monitoring report for 2010-2011 (CQC 2011b:13) suggested that, following the [initial](#) review, MHA commissioners and compliance inspectors are working more closely together. The CQC published a joint working protocol for MHA Commissioners and compliance inspectors, to promote joint and coordinated visiting, pooled expertise and report sharing (CQC July 2011d). It is encouraging to hear that there are some examples of inspectors taking MHA Commissioners' visit reports into account when assessing a provider's compliance, and some inspectors and MHA Commissioners will combine forces by visiting a service together. The monitoring report highlights the importance of a coordinated response between MHA Commissioners and compliance inspection staff (2011b:12-14). It recognizes that the evidence collected by MHA Commissioners can help to give a picture of the operation of the Mental Health Act across a provider and to identify where wider problems lie. This information can then be used to evaluate whether essential standards are being met and for the CQC to take enforcement action where necessary. The CQC's Annual Report for 2010/11 includes an example of a MHA Commissioner working closely with the Compliance Inspector by carrying out a joint inspection and producing a joint report, which identified a number of concerns about a hospital in London providing mental health services. There are also specific examples provided where MHA Commissioner findings have triggered a review of compliance with the essential standards (CQC 2011b:35 and 55). And in this way, the CQC should be able to use the wider regulatory framework to strengthen the protection given to people subject to the MHA [\(CQC 2013d: 10\)](#). It should also be able to avoid

unnecessary duplication and guard against discrepancies in reports to providers, provided, of course, that the spirit of cooperation is evinced on the front line inspections. This could be a major obstacle, as it is unclear the extent to which this team-working spirit and protocol is being consistently followed on the ground. As has been found elsewhere in public sector joint working, often the reality does not meet the rhetoric, particularly when those involved have inadequate cross-professional understanding, different agendas as well as distinct organisational cultural differences and distrust (Glover-Thomas 2007:224).

Conclusion

A number of key features outlined above have highlighted how the MHAC adopted a proactive, rights-based and patient-centred approach to its monitoring role. The presence of an effective national monitoring body in line with OPCAT is essential, and early indications suggest that the CQC is attempting to maintain and (in some respects) enhance the approach carried out by its predecessor, the MHAC. The retention of experienced MHA Commissioners, the maintenance of a preventive visiting regime (though, worryingly, perhaps less direct contact with detained patients) coupled with the continued involvement of service users in the monitoring role and its rhetorical commitment to embedding human rights, are all noteworthy examples. A recent CQC annual report has included Mental Health Act monitoring as one of eight delivery priorities for 2011/12 and beyond (CQC 2012:37). Moreover, the CQC is attempting to promote a legitimate system of rights-based regulation in many respects: by focusing on service user participation, human rights and due process; by preserving appropriate expertise; and by promoting accountability and external scrutiny through the submission of annual reports to Parliament and the publication of priorities and objectives.

But the CQC is still in its infancy in comparison to the MHAC, and we have yet to see whether it will be able to preserve the depth and breadth of monitoring commitment evinced by its predecessor. It does take time for organizations such as the CQC to effect change and earn the trust of the regulated bodies and wider public:

It is self evident that an evolutionary process in which knowledge and expertise accumulates and develops over time... is necessary for

confidence in any system to take root....A regulatory body only succeeds to the degree that it has the confidence of the wider population that it serves, including those who are patients and those who work in health care institutions (Oyebode et al 2004:240).

The abuses uncovered at Winterbourne View, and the findings of mismanagement and distorted priorities at the CQC suggest that there have been extremely turbulent times for the organisation. It still has a long way to go in gaining the respect and confidence of patients, staff and the general public. Its success in doing so will be determined by the amount of resources which are made available to it by the government, how well it manages the public's expectations, as well as how effectively the organization is able to align the different aspects of its work and manage the future expansion in its scope. Significantly that now includes the registration of primary medical services in 2012 and 2013, although fortunately, the CQC's remit will not now be extended to include the functions of the Human Tissue and Human Fertilization and Embryology Authorities, following the outcome of a public consultation in 2012.²⁴ Even so, the CQC now regulates more than 21,000 care providers operating services from more than 36,000 locations. The inclusion of primary medical services ~~last year has recently~~ added a further 8,000 providers and locations. In addition, the legal requirements of the Health and Social Care Act 2008 mean that providers must be registered and accountable for each separate regulated activity they provide. The CQC itself has acknowledged that it has struggled at times with the sheer amount of processing and recording of data involved, which led to a backlog of applications (CQC 2012:7 and 11).

It is now crucial for the CQC to manage the public's expectations in a more realistic way and raise awareness of its limitations. The CQC can promote and encourage good quality care, but it cannot completely eliminate abuse and

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The government had initially considered expanding the scope of the CQC to embrace these functions as well as the work of the MHAC, but the government decided not to proceed with this aspect of the proposal following a public consultation in 2012. The three regulators have instead developed a Memorandum of Understanding to promote joint working, share information and avoid duplication. See CQC Press Release, *Working with the Human Tissue Authority and Human Fertilization and Embryology Authority* 8 January 2012 located at www.cqc.org.uk.

deliberate mistreatment, especially where that abuse is concealed. There is also a responsibility on care providers and staff to deliver good quality care and meet the essential standards. The National Audit Office specifically commented on the public's high expectations of the regulator in its report into the CQC. One of the key findings in the report by the Comptroller General was the gap between what the public and providers expect of the CQC and what it can achieve as a regulator (HC 1665:7). This is partly due to the fact that the Commission's role has changed over time, and that has not always been communicated effectively.

The CQC is seeking to address some of the criticisms by developing a new strategy in consultation with the public, and by setting out more clearly what the public can expect from it. The new strategy was launched in April 2013²⁵ and the overall focus has been placed on increased service user involvement and promoting patient rights. The regulator is taking positive steps to publish better information for the public, introduce national teams with specialist expertise and develop new standards of care. Specifically, with respect to mental health monitoring, there is a commitment to strengthening patient rights in line with the OPCAT requirements and to align more closely the mental health and mental capacity (DoLS) oversight (CQC 2013c:21). The CQC has also pledged to continue to involve people with direct experience of mental health care more extensively in its inspection and monitoring work, through the Experts by Experience programme (CQC 2013c:22; CQC 2013d:11). There is also a commitment to improve the training and guidance to front line staff on mental capacity in particular (CQC 2013c:21) as well as improving the integration of regulation and Mental Health Act monitoring (CQC 2013d:10). This new approach will be developed over the next 12 months in consultation with key stakeholders in the mental health sector (CQC 2013d:3) e strategy These changes are promising and suggests that the CQC is committed in principle to improving improving—the mental health inspectionmonitoring system and OPCAT compliance. As highlighted in this article, these are key areas where further development is required for the CQC to strengthen its protection for detained

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See further www.cqc.org.uk

patients. However, the CQC's budget is less than the combined budget of its predecessor bodies, although it has significantly more responsibilities (HC 1665:7). It can only achieve its aims if it is well-resourced, well-managed and has a clear sense of purpose and strategic direction. The appointment of a new Chief Executive from September 2012 ~~should~~ ~~may~~ go some way towards achieving this. But this new 'super' Commission has not yet managed to gain the full respect and confidence of the public, or the health and social care practitioners who work in the regulated sector. As identified at the beginning of this article, this latter factor is essential in terms of the influence and 'impact' that the CQC will be able to make to drive improvements in adult health and social care. In contrast, the MHAC was generally well regarded and respected within the mental health field, though it wasn't able to exert sufficient political pressure or 'bite' on wards/units that were failing.

The CQC is facing an uphill struggle and its capacity to rebuild trust is likely to be hindered by its diverse and expanding responsibilities. There is a considerable danger that mental health monitoring could become subsumed within the wider regulatory focus of general healthcare inspection and registration' particularly given the ever-increasing scope of that regulation. Thus far, mental health monitoring does seem to be forming a distinct and important focus of the CQC's work and the new strategy suggests that will continue for the next few years (CQC 2013d). There is plenty of opportunity for the CQC to embrace a proactive rights-based regulatory approach to monitoring mental health care, as it acknowledged when it published its Equality and Human Rights Scheme in 2010:

'...we have a unique opportunity to consider how equality and human rights can be embedded in everything we do – our aim is to weave equality and human rights into the day-to-day fabric of our work... We have a real opportunity, through the new registration system, to do things differently, to focus on outcomes for people and to take their experiences into account. We must put people who use services, their families and carers at the centre of everything we do...' (CQC 2010a:2)

Let us hope that, with the CQC's reinforced rights-based strategy, commitment to strengthen mental health inspections and increased focus on

service user involvement, the reality will meet that rhetoric to protect the rights and standards of care for psychiatric patients.

References

Association for the Prevention of Torture, *Establishment and Designation of National Preventive Mechanisms* (Geneva 2006)

Baldwin R. and Cave M., 1999. *Understanding Regulation: Theory, Strategy and Practice*. Oxford University Press.

Bingley W. 2011. Monitoring the use of the Mental Health Act in 2009/10 . *Journal of Mental Health Law*, Spring, 120-124.

Boyes S. and Gunn M.J. 2007 'Law, Regulation and the Mental Health Act Commission' in Shaw I., Middleton H. and Cohen J., *Understanding Treatment without Consent: An Analysis of the Work of the Mental Health Act Commission*. Ashgate

Care Quality Commission and Equality and Human Rights Commission, 2011. *Equality and Human Rights in Essential Standards of Quality and Safety* (CQC/EHRC).

Care Quality Commission Briefing, *The MHAC Biennial Report 2007-2009 Key lessons and the Care Quality Commission's response* (20 July 2009).

Care Quality Commission, 2010a. *Equality and Human Rights Scheme 2010-13* (TSO).

Care Quality Commission, 2010b. *Monitoring the use of the Mental Health Act 2009/10: An overview of the CQC's findings from our first annual report on our monitoring of how the Act is used* (TSO).

Care Quality Commission, 2011a. *The State of Health Care and Adult Social Care in England: An Overview of Key Themes in Care 2010/11*, HC 1487 (TSO).

Care Quality Commission, 2011b. *Monitoring the Mental Health Act in 2010/11* (TSO).

Care Quality Commission, 2011c. *The Deprivation of Liberty Safeguards 2010/11* (TSO).

Care Quality Commission, July 2011d. *Aligning the activities of Mental Health Act Operations and Compliance Teams: A Management Protocol* (CQC).

Care Quality Commission, 2012. *Annual Report and Accounts 2010/11* (TSO).

Care Quality Commission, 2013a. *Monitoring the Mental Health Act in 2011/12* (TSO).

Care Quality Commission, 2013b. *The Deprivation of Liberty Safeguards 2011/12* (TSO).

Care Quality Commission, 2013c. *Raising standards, putting people first: Our Strategy for 2013 to 2016* (TSO)

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Care Quality Commission, 2013d. *A fresh start for the regulation and inspection of mental health services* (TSO)

Formatted: Font: Italic

Cavadino M. 1995. Quasi-government: the case of the Mental Health Act Commission 8(7) *International Journal of Public Sector Management* 56-62.

Clayton M. 2002. The Separation of the Commission's Functions: Inspectors, Visitors and Advocacy *Journal of Mental Health Law*, July, 97-104

National Audit Office, *Ninth Report: Annual Accountability Hearing with the Care Quality Commission*, HC 1665, Session 2010-11

Glover-Thomas N. 2007. Joint working: Reality or Rhetoric in Housing the Mentally Vulnerable? 29(3-4) *The Journal of Social Welfare and Family Law* 217-231

Hale B. 2010 *Mental Health Law* (Sweet and Maxwell)

Huisling R. and Silbey S. 2011 Governing the gap: Forging safe science through relational regulation. 5 *Regulation and Governance* 14-42

McHale J. 2003 Standards, quality and accountability – the NHS and mental health: a case for joined-up thinking? 25(4) *The Journal of Social Welfare and Family Law* 369-382

McSherry B. and Weller P. (Eds.) 2010. *Rethinking Rights-based Mental Health Laws*. Hart Publishing.

Mental Disability Advocacy Centre, *Recommendations by the Mental Disability Advocacy Center to the European Committee for the Prevention of Torture, on Aligning its Standards to the UN Convention on the Rights of Persons with Disabilities* (March 2010)

Mental Health Act Commission, 2006. *Strategy on Equality and Human Rights* (MHAC)

Mental Health Act Commission 2008. *Risk, Rights, Recovery Twelfth Biennial Report 2005-2007* (TSO)

Mental Health Act Commission 2008. *From Strength to Strength: Report on the first two years of the Mental Health Act Commission Service User Involvement Strategy* (MHAC)

National Audit Office, Department of Health The Care Quality Commission: *Regulating the quality and safety of health and adult social care, Report by the Comptroller and Auditor General*, HC 1665, Session 2010–2012

Oyebode F. et al, 2004. Commission for Health Improvement and mental health services 28 *Psychiatric Bulletin* 238-240

Parliamentary Joint Committee on Human Rights, *The Human Rights of Older People in Healthcare*, HL 156, HC 378, Session 2006-7

Parliamentary Health Committee, Annual Accountability Hearing with the CareQuality Commission, HC 1430, Ninth Report of Session 2010-12

Prosser T. 2010. ‘The Care Quality Commission’ in *The Regulatory Enterprise: Government, Regulation and Legitimacy* (Oxford University Press)

Quick O. *A scoping study on the effects of health professional regulation on those regulated*, Final report submitted to the Council for Healthcare Regulatory Excellence (May 2011)

Royal College of Psychiatrists, *Health and Social Care Bill 2007: Second Reading Briefing - House of Commons* located at www.rcp.org.uk

Steinerte E., Murray R. and Laing J. 2012. Monitoring those deprived of their liberty in psychiatric and social care institutions and national practice in the UK 16(6) *The International Journal of Human Rights* 865-882