abbreviation BPSD.[2] Certain physical restraints have the potential to cause serious injury and death,[5] and locked doors and bean bags, which are also physical restraints, are anathema to some. No evidence exists that "subjective barriers" such as patterns on the floor, mirrors, curtains, or other forms of camouflage on doors reduce wandering, but the possibility of harm, particularly psychological distress, cannot be excluded.[6] There may be ways of understanding what a person's wandering means in order to allow potentially helpful psychosocial interventions.[2]

Is there anything wrong with electronic tagging? Evidence from small unsophisticated studies comparing events or attitudes before and after the installation of boundary alarms shows that such systems are effective and can decrease stress in carers and patients.[7] But more robust evidence is needed. Carers like the idea of electronic tracking devices if these can ensure that the wanderer is found more swiftly.[8] Some argue that for the sake of safety a slight loss of liberty is a price worth paying and that concern about privacy has force only if we imagine that the person involved is trying to hide.[9] In the paradigmatic case of someone with moderate to severe dementia who wanders, electronic tagging arguably satisfies an ethical principle and decreases stigma. Being lost and half dressed in the middle of the night near a dual carriageway is hugely stigmatising, and electronic tagging may avoid this.

And yet, what of civil liberties and human rights?[10 11] Not everyone is a paradigmatic case. At the margins the need to protect the right to privacy, even in mild dementia, should be recognised. However severe a person's dementia, it should not be taken for granted that his or her need to wander is simply a matter of pathology that requires management rather than understanding. Although tagging might increase liberty in some senses, it has the potential to decrease autonomy and tracking devices might settle the anxieties of others without attending to the needs of the person with dementia.

It seems important, then, for the libertarian flag to be kept flying—for the sake of the individual and even in the face of convincing evidence (which is not yet apparent) that tagging improves overall quality of life. The risks and restrictions of alternatives to tagging, including the loss of privacy entailed in benign surveillance, should be kept in mind. But the use of such devices, even by families, must be considered carefully. This should be no more than good clinical practice, perhaps in due course supported by legislation regarding decisions concerning people who lack capacity. People with dementia might have capacity to make this particular decision, and their views should be respected. In the absence of this capacity, a decision will need to be made about the person's best interests, but this does not just mean the person's best medical interests. Rather, the determination of what is best will require careful inquiry, negotiation, and judgment. It is especially at this point that understanding the wandering behaviour and looking for the least restrictive ways of dealing with it will become imperative.[12] Where no consensus can be reached, the courts might have to decide. This is not, however, a sign of failure but of recognition of the seriousness with which we should regard the erosion of a person's liberty and privacy, especially when he or she has dementia.

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1 BBC News. *Electronic tagging for Alzheimer's*. Friday 27 September, 2002. news.bbc.co.uk/1/hi/England/2284537.stm (accessed 3 Oct 2002).
2 Ballard CG, O'Brien J, James I, Swann A. *Dementia: management of behavioural and psychological symptoms*. Oxford: Oxford University Press, 2001.
3 McShane R, Gedling K, Keene J, Fairburn C, Jacoby R, Hope T. Getting lost in dementia: a longitudinal study of a behavioral symptom. *Int Psychogeriatr* 1998;10:253-60.
4 Hope RA, Fairburn CG. The nature of wandering in dementia: a community based study. *Int J Geriatr Psychiatry* 1990;5:239-45.
5 Parker K, Miles S. Deaths caused by bedrails. *J Am Geriatr Soc* 1997;45:797-802.
6 Price JD, Hermans DG, Grimley Evans J. Subjective barriers to prevent wandering of cognitively impaired people. *Cochrane Library*. Issue 4. Oxford: Update Software, 2001.
7 Blackburn P. Freedom to wander. *Nursing Times* 1988;84:54-5.
8 McShane R, Gelding K, Kenward B, Kenward R, Hope T, Jacoby R. The feasibility of electronic tracking devices in dementia: a telephone survey and case series. *Int J Geriatr Psychiatry* 1998;13:556-63.
9 McShane R, Hope T, Wilkinson J. Tracking patients who wander: ethics and technology. *Lancet* 1994;343:1274.
10 Counsel and Care. *People not parcels—a discussion document to explore the issues surrounding the use of electronic tagging of older people in residential care and nursing homes*. London: Counsel and Care, 1993.
11 Bewley C. *Tagging—a technology for care services?* London: Values Into Action, 1998.
12 Oppenheimer C. Practitioner commentary (Case 8.1). In: Dickenson D, Fulford KWM, eds. *In two minds: a casebook of psychiatric ethics*. Oxford: Oxford University Press, 2000:266-7.

# The I in the new CHAI

*New regulatory hybrid may send contradictory messages to health professionals*

The Secretary of State for Health of the United Kingdom has issued a rallying call to "unleash the spirit of public sector enterprise."[1] The problem, however, is that the current regulatory environment tends to reinforce a culture of compliance rather than enterprise. This risks a vicious cycle in which trust is undermined through an overbearing approach to accountability.[2] This month the Commission for Health Improvement (CHI) published its corporate strategy for itself and its transformation into a new super-regulator of health care.[3] But behind the fine words of the strategy lie major obstacles.

The NHS Reform and Health Care Professions Act 2002 expanded the remit of the commission and gave it more "teeth."[4] It requires the commission to publish information on performance and a revised star ratings

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system (from next year). It also gives the commission new powers to recommend franchised management, suspension, or closure of any service found wanting. In April 2002, the government announced plans for a new Commission for Healthcare Audit and Inspection (CHAI) to subsume the existing Commission for Health Improvement and incorporate the audit commission's value for money studies in health and responsibilities for inspecting and licensing private health care.[3] The new commission is likely to take shape in all but name in April 2003.[5]

If this is the start of a process of rationalisation and consolidation in the crowded regulatory field it is to be welcomed. The opportunities for linking performance data to a more tailored and targeted programme of inspections are notable, and it is good to see the regulation of the private and public sectors being tackled together. But rationalisation is not just about redrawing organisational boundaries to create an impression of common purpose. Underneath the new corporate wrapping there needs to be a simple and clear new whole. For the new commission, achieving this will mean overcoming confusion on three counts over its purpose, approach, and place in the wider regulatory and political systems.

Firstly, confusion may arise about the new commission's purpose. It will have four roles: setting standards (with the Department of Health), audit and inspection (of performance, clinical governance, and finance), improvement (alongside the Modernisation Agency), and enforcement (working with strategic health authorities). There are tensions here—setting standards, auditing compliance, ensuring improvement, and enforcing remedial action mean acting as lawmaker, prosecutor, judge, jury, and probation officer. The new commission is on its own in being asked to combine these roles, whereas other bodies (such as the regulators of healthcare professionals) are separating and clarifying the boundaries between these tasks.[6]

Secondly, these multiple roles require the new commission to adopt different and contradictory approaches, which in turn imply different and competing conceptualisations of effective regulation. For example, the process of auditing organisations' compliance with government targets implies one style of regulation—summative, quantitative, punitive, and centrally driven. It places the locus of accountability on individuals (usually managers) and views change as a managerially driven process. Alternatively, to look at the quality of care across whole health systems, or to hold a mirror up to healthcare organisations, suggests a different style—formative and qualitative.[7] It places the regulator within a local process of enabling and facilitating improvement.

Thirdly, the new commission's place in the wider regulatory and political system may lead to confusion. However successfully it manages to resolve internal tensions, it also needs to locate itself clearly amid a still confusing array of different bodies with different underlying approaches to regulation.[8] Here the new commission (like the healthcare organisations that it visits) shares responsibility with others, including government, for seeing things through the eyes of consumers rather than advocating responsibility at the organisational boundary.

Consequently, the new commission is faced with three challenges: clarity of purpose, coherence of approach, and independence from government. Achieving clarity means that "CHAI" has to choose a conceptual focus for its activities. The "I" in old "CHI" stood for improvement; in the new commission it currently stands for inspection. An emphasis on inspection implies a harder edged and more bounded identity. This is a misguided emphasis; inspection is just one element of a more developmental and holistic approach to improvement.[9] CHI needs to do battle over the "I" in the new CHAI.

To achieve coherence the new commission will have to dovetail potentially contradictory roles and approaches. If it wins the day over ensuring that improvement remains its characteristic stripe then coherence may be within its grasp. This will, however, entail casting off some of the regulatory burden that has already accrued over the Commission for Health Improvement's short life and radically changing the way in which it undertakes some of its new obligations, such as the star ratings system.

The third challenge, which underpins attempts to meet the first two, is for the new commission to achieve meaningful independence. As in the rest of the NHS the independence on offer is a deal that emphasises central control over direction in return for the lesser freedom over how to travel. For example, the government will pick the targets used to determine star ratings while allowing the new commission the freedom to adjust the methodology.[10] The political attraction of such a position is that it will allow the government to present the new commission by turns as evidence of government toughness as well as testimony to its new devolution of power.

The secretary of state argues that there is no contradiction in this sort of third way stance: "Where there are persistent problems we will step in—where there is progress we will step back."[1] But does this simply hide a central uncertainty at the heart of New Labour's mindset? Does the government have a sound model for thinking about how change happens and who should be responsible for ensuring its achievement?

The new proposals for the Commission for Healthcare Audit and Inspection mix up independence and developmental intent with a limited and tightly controlled political mandate. The danger is that healthcare professionals will experience this type of regulatory hybrid as a bewildering set of contradictory messages. Processes that inconsistently redefine the relationship between professionals and government risk paralysing rather than unleashing the "modernisation" of both the service and its professional ethos.

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1 Milburn A. *Diversity and choice within the NHS: speech at the NHS Confederation conference 2002*. Speech delivered on 24 May 2002. www.doh.gov.uk/speeches/may2002milburnnhsconfed.htm (accessed 4 Sep 2002).
2 Baroness O'Neill. *BBC Reith Lectures 2002: a question of trust 2002*. Broadcast BBC Radio 4 on 3 April 2002. www.bbc.co.uk/radio4/reith2002/ (accessed 4 Sep 2002).
3 Commission for Health Improvement. *Corporate strategy to 2005 and business plan 2002-2003*. London: Stationery Office, 2002.

4 House of Commons. *The National Health Service Reform and Health Care Professions Act*. London: Stationery Office, 2002.
5 Department of Health. *Delivering the plan: next steps on investment, next steps on reform*. London: Stationery Office, 2002.
6 Commission for Health Improvement. *CHI news bulletin: Commission for Healthcare Audit and Inspection (CHAI)*. London: CHI, 2002. www.chi.gov.uk/eng/latestnews (accessed 16 Sep 2002).
7 General Medical Council. *Acting fairly to protect patients: reform of the GMC's fitness to practise procedures*. London: GMC, 2001.
8 Newman J. *Modernising governance: New Labour, policy and society*. London: Sage, 2001
9 Calman K, Hunter D, May A. *Make or break time? A commentary on Labour's health policy two years into the NHS Plan*. Durham: University of Durham School for Health, 2002.
10 Department of Health. *NHS performance ratings: acute trusts, specialist trusts, ambulance trusts, mental health trusts 2001/02*. London: Department of Health, 2002. www.doh.gov.uk/performanceratings/2002 (accessed 4 Sep 2002).

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1 ComScore Media Metrix, quoted on http://www.nua.ie (accessed 29 Aug 2002).


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