

Through a glass darkly: exploring commissioning and contract monitoring and its role in detecting abuse in care and nursing homes for older people

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Abstract

Purpose – *The purpose of this paper is to present findings from face-to-face interviews undertaken with 16 care and nursing home managers employed in homes situated in two English local authorities. The research sought to explore managers' perceptions of the role of contract monitoring in the prevention of abuse.*

Design/methodology/approach – *Semi-structured interviews were undertaken with 16 care and nursing home managers.*

Findings – *Though personnel employed by the local authority who conducted contract monitoring were generally thought of positively by care home managers on a personal level, their effectiveness was perceived to be limited as a result of their lack of experience and knowledge of providing care, and the methods that they were required to use.*

Research limitations/implications – *Though the research draws upon the experiences of only 16 care and nursing home managers in two local authorities, data suggest that current contract monitoring activity is of limited utility in determining the true nature of care and the presence of abuse.*

Originality/value – *Unusually, the paper explores care and nursing home managers' perceptions of contract monitoring processes in terms of how they perceive their effectiveness in preventing abuse.*

Keywords *Older people, Abuse, Empirical research, Adults at risk, Commissioning and safeguarding, Contract monitoring and safeguarding, Safeguarding policy and practice*

Paper type *Research paper*

Introduction

With the continued shrinkage of public sector owned and operated residential care home provision for older people, and the long-standing provision of long-term care to older people requiring nursing care in privately owned nursing homes, both of which are purchased in the majority by local authorities by means of their commissioning[1] functions, the importance of effective contract monitoring is ever more salient to ensuring high-quality care that is free from abuse.

This is particularly true given the limited effectiveness of statutory regulation in preventing abuse in care and nursing homes for older people, likely to be compounded by proposed changes to regulatory processes over the next four years or so that amount to a further dilution of current regulatory activity (Moore, 2017a).

As figures collated by The NHS Information Centre (2012), The Health and Social Care Information Centre (2014a, b, 2015) and NHS Digital (2016) have clearly demonstrated, 36 per cent of all safeguarding concerns emanated from within care and nursing homes, of which in excess of 40 per cent were substantiated or partially substantiated in each of the five periods. Similarly, the research of Moore (2016a, b, 2017b) has revealed the significant extent and nature of abuse that still occurs in private sector care homes for older people, and that a proportion of it

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remains unreported and is sometimes actively concealed. Further, it is apparent that abuse continues to be perpetrated in care and nursing homes rated as “good” by the Care Quality Commission (CQC), the statutory regulator (Moore, 2017b), yet local authorities and their partners in Clinical Commissioning Groups continue to spend many hundreds of thousands of pounds of public money each year not only to monitor the contracts they have with care and nursing home providers, but also to actively help them to overcome their inability (or reluctance) to comply with contractual requirements. That this is the case is particularly paradoxical given that care and nursing homes are managed by care managers registered with the CQC following a “fit persons” process that should, theoretically, ensure that they are suitable and capable of running a care or nursing home to the required standards. Similarly, contracts let to care and nursing home providers by local authorities invariably include, either implicitly or explicitly, many of the same standards required by the statutory regulator, and will, or should, in any case include a “boilerplate” clause that requires those to who the contract is let to comply with all statutory primary and secondary legislation from time to time in force. This naturally includes the Health and Social Care Act 2008 that, along with its attendant regulations, renders the current “fundamental standards of care” prescribed by statute to be legally enforceable.

The research described in this paper explores perceptions held by care managers of the nature and efficacy of current contract monitoring functions in preventing and detecting abuse of older adults who may be at risk, that, if detected, will almost invariably also confirm that not all of the required contractual standards are being met.

Reviewing the literature

Inveterate failures of care homes to meet prescribed minimum/essential standards

Long awaited National Minimum Standards (NMS) for all care homes in England were introduced by the Care Standards Act 2000. The Act also created the national regulator responsible for the enforcement of these standards, the National Care Standards Commission that became shortly thereafter the Commission for Social Care Inspection (CSCI). However, at the end of the first year of the full implementation of the new inspection regime, only 26 per cent of care homes were assessed as meeting the NMS, and at the end of the second year, 2004, 48 per cent were assessed as doing so (Her Majesty’s Government, 2005, p. 61). In 2005, after three years of revised regulation, 20 per cent of care home providers still failed to meet the NMS (Commission for Social Care Inspection, 2005, paragraph 8.24), and in 2006 21 per cent continued to do so (Commission for Social Care Inspection, 2006, p. 140). In the 2009 annual report produced by the Care Quality Commission, the current regulatory organisation that succeeded the CSCI, 17 per cent of care homes still failed to meet all of the minimum standards (p. 62). In 2012, the CQC reported that between 12 per cent and 16 per cent of homes were still not meeting requirements of what had by that time become the “essential” standards of quality and safety” (Care Quality Commission, 2012, pp. 12-3), and in the report for 2016, 26 per cent of residential care homes and 41 per cent of nursing homes were rated by them as either “inadequate” or as “requires improvement”, that is, they continued to fail to meet all of what were by that time termed “fundamental” standards (Care Quality Commission, 2016a, pp. 58-9).

In such prevailing circumstances, where many care homes continually fail to meet basic required standards, it is difficult to see how current regulation can be expected to reliably identify the subtler, often concealed institutional failures and practices that give rise to abuse. That abusive practices and regimes may remain undetected is also a particular concern given that the frequency with which care homes are inspected has fallen since the advent of the national regulator from a minimum of two each year to a variable frequency of up to only one inspection every three years, based upon assessment of risk using a range of indicators, including provider-generated self-assessments. As Kingston *et al.* (2003, p. 27) have argued, a key element of preventing the abuse of people who might be at risk in the care sector is stringent regulation and inspection, yet the Care Quality Commission (2011, p. 12) determined in its first overview of the care market that “Outcome 4, effective, safe and appropriate care” was one of three outcomes generating the most enforcement actions. Further, Killest *et al.* (2013, p. 131) concluded from their study of organisational cultures in ten care homes that an inspection report indicating

compliance with prescribed standards did not necessarily mean that care was of a good standard. Moreover, this echoes the previous research findings of Gilleard (1994, p. 101) and Cambridge *et al.* (2006, p. 22) who similarly found no correlation between compliance with prescribed standards and the presence of physical abuse. It is also hard to reconcile the numbers of care homes still failing to meet the “fundamental standards of quality and safety” with the CQC assertion that its purpose is to “[...] maintain a relentless focus on providers’ requirements to comply with essential standards [...]” (Care Quality Commission, 2011, p. 5), within an espoused role of “[...] protecting and promoting the health, safety and welfare of people who use services” (Her Majesty’s Government, 2008).

The rise of oversight and scrutiny by local authorities

In addition to the activities of the statutory regulator, the second force attempting to ensure that standards in care homes are as they should be, and that residents are protected from abuse, is the contract monitoring activity of 152 local authorities in England. After all, the statutory regulator is a “third party” to the principal-agent relationships between local authorities and the care homes with which they contract in the market-like context of providing care that came into being in 1993 as a result of the NHS and Community Care Act 1990[2]. As Marsland *et al.* (2015, p. 121) suggested, many of the early indicators of abuse are the “inverse of service quality indicators” and thus robust mechanisms of monitoring the performance of providers to the contract specifications that are required by local authorities are particularly important in preventing abuse in care homes.

Yet, when what is known as the “contract culture” took hold in the early 1990s little thought had been given to the fact that these new contracts between local authorities and private sector care providers would need to be monitored to establish and continually confirm the performance of the latter. The concept of the services to be provided under contract as “intangible”, as care services are, had not been considered by local authorities and their political masters (Walsh, 1995, p. 126), driven as they were primarily by containment of the ever spiralling cost of providing social care to the nation. Further, how the monitoring of the nature and quality of social care could actually be undertaken was new territory, beyond the prior experience of the social services functions of local authorities, particularly given that direct care giving falls into the category of “experience goods” that are virtually impossible to evaluate accurately before the service, the care required, is given, and this can only be done reliably during or after the service interaction between provider(s) of care and recipient of care (Moore, 2017a). The presence of cognitive impairments among service recipients serves to continue to compound this difficulty, and though it has always been a problem, it is particularly salient in contemporary care homes for older people where an estimated 70-80 per cent of residents are suffering with significant cognitive decline as a result of dementia (Department of Health, 2009a, p. 57; Alzheimer’s Society, 2013, p. 1). Though the review of individual residents by social workers following implementation of the NHS and Community Care Act 1990, and more recently by NHS nurses fulfilling a number of roles, might also be expected to contribute to the prevention of abuse, from the information and research currently available it is clear that abuse continues in care homes with notable frequency.

As a result of this failure to recognise the difficulties of undertaking effective contract monitoring, early attempts to monitor the performance of care home provision focussed primarily on information available to the contract monitor before the event(s) of care had taken place. Unfortunately, this remains largely the case to the present day, though there has been some focus on residents’ subjective experiences of care in more recent years. However, these attempts pay no heed to the fears of retribution, isolation and even eviction that have been found to be present among those residents who are able to express their views (Ramsey-Klawnsnik, 1996; Alzheimer’s Society, 2004, 2007; Gibbs and Mosqueda, 2004; Harris and Benson, 2006; House of Lords/House of Commons Joint Committee on Human Rights, 2007; Collins and Walford, 2008; World Health Organisation, 2008; Wells, 2009; Dixon *et al.*, 2009; Owen *et al.*, 2012; Flynn, 2015) and that the judgements of relatives and others who may visit the home are poor proxies where impaired cognitive ability prevents the views of residents being sought directly (Godlove *et al.*, 2004; Joseph Rowntree Foundation, 2008; Age UK, 2011). Consequently, it remains the case that “[...] if quality is not fully observable, opportunities for cutting quality exist [...]” (Propper, 1992, p. 18), and it is no great

conceptual leap from this assertion to appreciate how opportunities for residents in care homes to be simultaneously abused exist, given the countless, complex care recipient-care giver interactions that take place in care homes each and every day, many of which occur behind the physical barrier of the closed doors of bedrooms, bathrooms and toilets, including during the night and at weekends when any form of direct monitoring of performance to contract requirements from external agents is wholly absent (Moore, 2017b). The present-day exception to this is where some care home providers have very recently taken the initiative and installed closed circuit television cameras and digital recording equipment allowing usually retrograde observation of care recipient-care giver interactions, but to the author's knowledge, this remains confined to communal and transit areas and thus cannot detect the abuse that transpires all too frequently behind closed doors.

An ineffective "audit explosion"?

Following the changes heralded by the NHS and Community Care Act developed from 1993 onwards, an "audit explosion", as Clarke (2003, p. 155) described it, took place using the fundamentally flawed antecedent methodologies outlined above. In the author's direct experience, however, what Clarke described as an "explosion" was more like a gradual amoebic expansion throughout local authorities across England, often with authorities purloining the overly simplistic methods of contract monitoring used by their counterparts in neighbouring authorities without assessing their likely effectiveness, giving rise to an illusion of credibility of the procedures used without objective assessment of their true efficacy.

Remarkably, by 2000, the average percentage spent on procurement of services accounted for 41 per cent of all procurement expenditure in local government (Erridge, 2000). Yet, as Wistow *et al.* (1994) demonstrated, the understanding, abilities and indeed enthusiasm of local authorities to manage and monitor contracts was both limited and defective. Though, as Kettl (1993) asserted, regulation that comes out of the contracting process is a highly important part of the approach to contract management, by 2007 most local authorities still had, almost a decade and a half after the implementation of the NHS and Community Care Act, under resourced contract monitoring functions (Care Services Improvement Partnership, 2007, p. 8), thus limiting their "evaluation capacity" of performance by providers to contractual requirements (Brown and Potoski, 2003). This circumstance was further compounded by a profound reluctance and frequent resistance among providers, particularly the plethora of care home providers who had entered the "new" market of provision in the previous decade or so, to embrace the contract culture and the monitoring of their activities that came with it. This reluctance and hostility arose in part from what providers perceived almost ubiquitously as cumbersome requirements imposed upon them to maintain an ever increasing range of documentary evidence relating to the care they provided, and intrusive site visits to their facilities for contract monitoring purposes by local authority personnel who were often insufficiently experienced or qualified to undertake the task (Care Services Improvement Partnership, 2007, p. 17). This resistance included a tendency for local authority contract monitors to undermine what care home providers held to be their own infallible expertise (Knapp *et al.*, 2001), and their unwillingness to comply with the new scrutiny, coupled with the realisation that it was not going away, led many providers to engage in "creative compliance" (Walshe 2003, p. 163), that is, they created the illusion of compliance by providing the required organisational artefacts for inspection, paper records, for example, whilst simultaneously maintaining the patency of the institutional display of their care homes, thereby ensuring that those conducting inspections were none the wiser, a phenomenon that endures to this day.

The problem of imperfect information

Though the "early" indicators of poor quality care in care homes that give rise to circumstances where abuse of older people is more likely to occur may well be observable and tangible, as Marsland *et al.* (2015) asserted, such as a lack of direction and support from managers, it is also clear that such abuse remains unidentified and unreported to a significant extent, and may sometimes be deliberately concealed by the actions of care home staff (Greve, 2008; Moore, 2016b). Unfortunately, the reassurance that might otherwise arise as a result of staff holding recognised qualifications in care is illusory, because they are demonstrably over-represented among those proven to have perpetrated abuse against older people (Moore, 2017c). Of additional concern is that Moore (2017b)

has found that a significant proportion of care homes where abuse was reported to have been witnessed had, at the time the abuse occurred, been rated by the CQC as “good”. These findings certainly confirm that something remains awry with current methods of both statutory regulation and contract monitoring to prescribed standards that might otherwise detect conditions under which abuse is more likely to be perpetrated. The common practice of basing the scrutiny of care homes on assessments of risks, whether by the national regulator as is currently the case, or by contract monitoring functions, is also called into question by what Moore (2017b) found, given that homes rated by the regulator as “good” are unlikely to be prioritised for more frequent inspections or contract monitoring activity. In this way, assessments of the performance of care homes based on perceived risk, termed “responsive regulation” (Walshe, 2003, p. 41), often fail to detect poor care and abuse, because the stimulus to produce the response, that is, evidence of poor care and abuse, remains hidden by either the inaction or actions of care home staff.

But regrettably the plans of the statutory regulator to carry out fewer “comprehensive” on-site inspections of registered operators and an intention to place increased focus upon providers’ own assessments of their quality have recently been announced (Care Quality Commission, 2016b; The NHS Confederation, 2016). By doing this, and by making use of improved use of data and information, the CQC intends to maintain a risk-based approach to inspections whereby care homes achieving the current “top” two ratings of “outstanding” or “good” will be inspected less frequently than those rated as “requires improvement”, or “inadequate”. The regulator plans to be “intelligence driven” through the development of a “CQC Insight” system (Care Quality Commission, 2017, p. 14), that is, to make use of data from a variety of sources, including, for example, local authority and health commissioners. Thus, the need for local authority contract monitoring functions to become effective will soon be even more important if it is to inform the responses of the regulator, including influencing the likelihood of enforcement action being taken.

Yet, contract monitoring and review methodologies are still to overcome the uneven distribution of information about the true quality of care and the presence of abuse, the greater part of which lies with care home proprietors and their staff. This “asymmetry of information” (Milgrom and Roberts, 1992, p. 140; Moore, 2017a, p. 422) remains a major obstacle to the effective monitoring of the performance of service providers to this day. As Francis (2013, p. 677) remarked, for example, following the investigation of abuse at Stafford General Hospital:

[...] it’s very difficult to get a real in-depth view of how an organisation performs when you’re outside that organisation. Unless you’re in there all the time, seeing how services run, you can only ever get a snapshot for the time you’re in [...].

Though voiced in relation to investigations at an NHS hospital, the assertions of Francis are just as applicable to private sector care homes and illustrate how only imperfect knowledge of what goes on from day to day in care homes is available to external agents, such as contract monitoring personnel and inspectors. Though some authorities have attempted to improve their monitoring activities by introducing joint monitoring between both social services and health personnel, and even on occasion inspectors employed by the statutory regulator, the fundamental problem of imperfect information remains a significant barrier to effective scrutiny of providers’ activity.

Consequently, though care managers in care homes are also constrained in what they know of the true functioning of the homes that they manage, they are well placed to give insights into the effectiveness of contract monitoring activity undertaken by external agents.

Method

In total, 16 semi-structured, face-to-face interviews were conducted by the author with eight registered residential and eight registered nursing home managers, four residential and four nursing in each of two Metropolitan Borough Council areas in the West Midlands. Participants were recruited from homes registered with the CQC to look after older people and older people with dementia, and that were rated as “requires improvement” or “good” by the regulator at the time the interviews were undertaken.

Respondents anonymity was assured during the recruitment exercise to enable them to feel able to comment freely during interviews and to express any less favourable opinions and experiences

that they might have had without fear arising from the perceived possibility of repercussions from the local authority that could affect the profitability and survival of the businesses they managed and/or, for the same reason, prohibition of their participation by their employers, the care or nursing home proprietor(s).

Before the interviews were carried out participants were asked to provide an overview of the nature and frequency of the contract monitoring they received from each local authority to establish the methodologies in use. From collation of these conversations, it emerged that the local authorities in which participating care and nursing homes were located employed two principle processes to conduct contract monitoring of homes for older people in their respective areas.

Local authority A: conducted one annual on-site visit to each care and nursing home undertaken by (usually) one contract monitoring officer, and also required a monthly return to be submitted containing information that was exclusively numerical information apart from one indicator that asked about type(s) of training delivered to staff in the previous month. In the event of specific issues relating to contract requirements, such as those arising from safeguarding concerns, additional on-site visits from commissioning personnel might occur, but these were reported to be infrequent.

Local authority B: had discontinued routine monitoring of all care homes involving site visits, though providers were required to submit periodic returns, again quantifying such occurrences of residents having falls and the numbers of deaths. Instead, in the event of problems detected in any given home, as a result of, for example, CQC inspection reports, safeguarding concerns or complaints, a “care home improvement team” would engage with the home, including by means of site visits, to provide guidance and instruction to overcome presenting issues. The “improvement team” would include contract monitoring staff of the local authority working with other personnel dictated by the nature of the perceived problems, such as infection control specialists and district nurses.

Interviews were conducted between June and August 2017 with care managers at each of the participating homes in line with participants’ expressed wishes. Interviews each lasted for between one and two and a half hours and were digitally recorded with respondents’ consent to allow the interviewer to concentrate on the interview itself and to facilitate ease of later transcription and scrutiny. Interview questions were designed to explore care managers’ perspectives of current contract monitoring methodologies, their effectiveness or otherwise, and the impact they might have on the occurrence of abuse. Open questions were used to encourage participants to express their views and experiences. There was thus an acknowledgement that during interviews there might be significant departures from the question schedule, but this was found to be beneficial to the exploration of facets of experience and perceptions among respondents not previously considered by the research questions, leading the interviews to become sites of knowledge construction (Hand, 2003, p. 17; Dunne *et al.*, 2005, p. 32).

Analysis was undertaken by the author using the thematic form of narrative analysis (Riessman, 2004), a method suitable for non-probabilistic samples of the kind selected for this research, and in accord with its inductive, exploratory purpose wherein a priori categories into which data may fall have not been established. By employing thematic analysis the author was able to detect and isolate the range of interpretations and issues held and raised by research participants that were relevant to the research objectives (Hatch, 2002; Creswell, 2014). In this way, segments of data within the interview transcripts were identified and classified using “codes” according to their similarities and any emerging patterns (Miles and Huberman, 1994; Braun and Clarke, 2006; Creswell, 2014), leading to a reduction of the mass of gathered information, “[...] sorting, focussing, discarding and organising data in such a way that final conclusions could be drawn [...]” (Miles and Huberman, 1994, p. 11). The thematic analysis thereby “[...] focused on identifying and describing both implicit and explicit ideas [through] codes developed for ideas or themes [...]” (Namey *et al.*, 2008, p. 138). Coding thus allowed the author to review the whole of the data by identifying its most significant meanings (Miles and Huberman, 1994; Coffey and Atkinson, 1996) extracting from it salient common perceptions from among respondents, with each of the “themes” capturing something important from respondents narratives in relation to the research question, thereby identifying patterns within responses (Braun and Clarke, 2006, p. 10).

A second, independent reviewer also scrutinised the interview transcripts, coding the raw data using the same thematic method. This enabled the author and independent reviewer to compare the two “sets” of codes and themes derived from the data, enhancing the reliability of the analysis undertaken. Though a high level of correspondence was found between the themes identified by both the author and the reviewer, it was agreed by both that isolated segments of verbatim responses could arguably be reflective and/or supportive of more than one theme. In the presentation below of what was said by respondents, this will become clear to the reader, yet further reduction of the data tends to lead to a loss of meaning and significance of what was said for the purposes of this paper.

The sample

All of the care and nursing homes registered with the CQC to provide care to older people and older people with dementia and with a current rating of “requires improvement” or “good” in areas A and B were written to. Though relatively few homes in either area were rated as “inadequate” and only one as “outstanding” at the time of the research, it was deemed that excluding these “outliers” would lend greater reliability to the research by targeting the most numerous categories of compliance into which care homes had been placed by the regulator. The communication sent to the homes included an explanation of the nature of the research and its purpose, and invited expressions of interest in participation. The care managers of 46 care and nursing homes out of a combined total of just over 100 that met the criteria subsequently offered to take part. From this group care managers that were confirmed as registered as such with the CQC and who had been in post for a minimum of two years were isolated, from which the 16 care managers to be interviewed were randomly selected. This was done in order to ensure, as far as possible, that respondents possessed the insights and experience of contract monitoring processes likely to lend credibility to the data secured during the research.

Findings

The thematic analysis enabled the identification of five principle themes arising from the experiences of care managers. The sections that follow are headed with *in vivo*, verbatim responses, that is, in the language of the responses given by interview participants (Birks and Mills, 2011, p. 94), and reveal perceptions likely to be of significance to consideration of how conduct monitoring is undertaken, as follows.

Contract monitoring is superficial

Registered care managers referred ubiquitously to what they perceived as the superficiality of the contract monitoring processes they had experienced, for example:

We have to supply monthly figures to the local authority. Numbers of accidents and falls, for example, mostly just numbers [...] how many staff have left, that kind of thing [...] meaningless [...] contract monitoring is superficial if you ask me, these numbers don't tell anyone much at all about the quality of care or whether people may be being abused.

I always send in the numerical returns the local authority requests. Yes sometimes the numbers are high, for example the number of pressure sores that develop. But what they [the local authority] must realise is that many of the people here are dying. And that is most of the people in this home unfortunately [...] they are very prone to pressure sores, despite our best efforts [...] they get Kennedy[3] terminal ulcers that are essentially unavoidable in those who are dying. They are not being abused, they are dying for heaven's sake. Its ok. We are happy with the process though, don't get me wrong because it's not demanding of us and very superficial. They just check records, things like the record of training staff have had, and if they are in order there isn't a problem, we usually get a clean bill of health.

Its fine really. We just leave them to look at our records of training, recruitment checks, assessments of the residents and care plans and that's it really, this contract monitoring is superficial, just paperwork. They were talking about giving us a rating of “gold” or “silver” or “bronze”, based on that, but that plan was abandoned because they finally realised it would not necessarily match the ratings of the

inspection unit [this refers to the Care Quality Commission]. Daft really because everybody knew the inspection unit was going to bring back the old quality ratings and there are four of those [levels of quality rating], not that it matters either way because they both only look at our written records mostly and these don't mean people are not being abused.

Well this authority doesn't do routine visits any more as you probably know. They concentrate on the homes where they know there are problems. The trouble is there are plenty of homes with problems, where care is bad and people are abused that they don't know about. That's the trouble with it [the local authority's monitoring method] it's too superficial and only works if you know all the homes where abuse is happening and they don't know that because they can't see into homes and the paper records and the numbers we send in to them [the local authority] won't reveal abuse.

The local authority sends in what they call a quality improvement team [...] but the staff behave differently when they are around [...] they don't take the shortcuts they routinely take [...] they know what's right from wrong, they just don't do it the right way when they can't be seen [...] talk about scratching the surface!

Respondents also spoke of how the superficiality of contract monitoring was compounded by an absence of any detailed scrutiny of their written policies and procedures by those who monitored contracts. They also clearly recognised how care staff would behave differently when those responsible for monitoring contracts were present in the care home, and suggested that policies and procedures, whatever their calibre, were in any case sometimes ineffective unless some form of oversight of staff was constantly present.

Abuse happens behind closed doors ... and at night

Respondents universally recognised not only the superficiality of contract monitoring processes, but that the site visits that were made by external personnel were not only unable to penetrate the barrier of the closed door behind which personal care was usually provided to residents, but also that such visits were only undertaken during "office hours" when there was little chance of the true nature of the care home environment being observed, as follows:

How can it [contract monitoring] prevent abuse? No, not the monitoring as we get here. They check our records for sure, things like staff training and care plans, but though everything is ok in this home, in others, looking at those things isn't going to prevent abuse, is it? When it comes down to it most of the abuse that happens, happens behind closed doors in the bedroom or bathroom, well it does in my experience, when training sometimes goes out of the window. Why? To get the job done I suppose! But all the contract monitoring staff see is what a home wants them to see and the truth won't be found in bits of paper.

I don't think contract monitoring or inspection even, can stop abuse. After all most of it, what we have seen on the telly, has been in residents' bedrooms. Or at night time sometimes, when there's only usually a few staff and no managers as such. And in any case managers can collude with abuse you know. But no one records abuse in the daily notes do they, well not if they've done it!

If nothing else I think monitoring staff should go to homes without prior notice and they should go at weekends and in the night [...] and after or before office hours. That when they are more likely to find abuse going on. The inspection unit [the statutory regulator] used to do this many years ago and this was effective [...] quite a few homes were caught out for abuse.

There shouldn't be warning of the contract monitoring visits! That just gives homes the time to clean up, put things in place and make sure more staff are around [...] what the person monitoring the contract sees is not what goes on at any other time behind closed doors and at night time and weekends.

Don't forget, the quality improvement team people are only here during office hours and we all know when they are going to arrive and when they are going to leave [...].

That the modus operandi of contract monitoring staff visiting the home only during "office hours" was known to care staff within the care home was apparent from the responses of care managers. It became clear from interviews that though care managers were unperturbed by the superficiality of the contract monitoring processes to which their homes were subject, they did recognise that such monitoring was rendered ineffective, in part because site visits were almost without exception conducted by external personnel with prior notice during the nine to five working day.

Contract monitoring staff do not have a clue what working in a home is all about ... they do not really know what they are looking at

A significant number of care managers asserted that the contract monitoring staff they encountered did not have the necessary experience and/or knowledge to enable them to have any hope of monitoring contracts effectively, for example:

One or two I've got some respect for, or had in the past, because they had worked in nursing homes or hospitals, so they knew what they were talking about, but they I suppose inevitably moved onward and upwards and this lot we've got now, well most are nice enough people, but they don't have a clue what working in a home is all about and what needs to be looked at to see if people [residents] are ok and being looked after.

It's all about paper records again now, things like policies and procedures. These things don't necessarily tell you how well people are looked after, care plans as well are an example, even if they are well written [...] just because they are there doesn't mean the care staff are gonna stick to them. Care staff tend to do their own thing, especially if they are not supervised well. But the contract staff don't seem to question this, they just see that we have a thick file or two of policies, a care plan for each resident with some evaluations and that's it [...] they don't really know what they are looking at, they don't know much at all about how people should be cared for because they have never worked in care homes.

They are fine as people mostly. But most we have come to see us now have worked in offices or unrelated jobs [to care and nursing homes] so they don't know what is good care and what is not. All they seem concerned with is looking at our paper records so they can put a tick in a box. The closest they get to residents is looking at the care plans we write, but how can they comment on these when they have never provided care themselves, never looked after people? I don't really see how people who are not nurses can make a judgement as to the care and safety of people in nursing homes really.

They don't know much about giving care to people, especially nursing because they are not people who have ever worked in homes. They wouldn't know how to tell a bruise from a senile purpura, or how to easily tell if someone is dehydrated. They don't know what should or needs to be in training for it to be any good [...] but we don't mind if I'm honest, it makes our lives easier [...] just wave the bits of paper around and they go away happy.

They [the quality improvement team] have given us some guidance in writing our care plans, or tried to, they don't really know themselves because they have never worked in a home, but what they don't realise is that the biggest problem is getting the staff to stick to the plans, like those care staff who are a law unto themselves and do what they have to do to their own plan, their own way of thinking [...] working [...] usually to save time. You can't blame them I suppose in one way, there is a lot to be done, but that's when abuse comes in. People [residents] are rushed, maybe not washed and cared for properly, not lifted safely, that kind of thing.

I think it [contract monitoring] is an important job, fundamental actually, so you have gotta have people who know what working in a home is really like [...] they can be aware of the shortcuts and the tricks of the trade that happen [...] these are usually abusive [...] but the monitoring staff we see have usually never worked in care homes [...] we even have staff who worked in offices, typists, monitoring contracts [...] but at least it gives us an easy life.

It was apparent from respondents that, in their experience, contract monitoring staff lacked the necessary insights to appreciate that what they were scrutinising was unlikely to be a true representation of the care that residents actually experienced. Interviewees frequently mentioned the erroneous assumption made by those monitoring contracts that if Criminal Record Bureau and Independent Safeguarding Authority Checks, employment references, records of training and stipulated policies and procedures were in place, then care would be good and abuse would not be perpetrated.

Only those directly receiving care can tell of the care they receive

The lack of insight among monitoring staff and superficiality of monitoring processes were also reflected in interview respondents' assertions that the people actually receiving care were those who were in a position to comment most accurately on its quality:

Only those directly receiving care can tell of the care they receive, not their relatives and certainly not care plans, policies and procedures [...].

If I'm honest I think they should talk to residents and their families to find out if everyone is happy here. They check all of the records we keep, well a sample of them, and take it that the care must be good as a result, but really they should know that written records like that don't really tell if the residents are happy and safe [...] but I don't believe they understand what the job of looking after people is all about, so talk to the residents I say, and the families.

I certainly think residents should be spoken with. I know most have dementia these days, but a few can talk to you and tell how it is for them if you spend time with them. If they can't, then residents' relatives should be spoken to, that's the next best thing I think.

Definitely by talking to patients where this is possible. They [the local authority] started doing this a few years back, but I think there was a change in management and now all they do is look at paper records which don't tell anywhere near the true story. That's why we still have bad homes in this area and why we see old people being abused on television, that's why looking at just records was a backward step. They lost the plot in this borough somehow.

The majority of respondents recognised the difficulty associated with residents who were cognitively impaired being able to contribute to contract monitoring processes, and a number that the opinions and observations of relatives and friends of residents were an unreliable substitute, for example:

Some of those in the quality improvement team talk about what they call the 'mom test', something that came from somebody in the Care Quality Commission [...] its where you ask yourself in the care you see is good enough for your mom or dad [...] trouble is not everyone actually likes there mom and dad and they are glad to get shut of them, so they don't much care if they are abused [...] not everyone is a saint I'm afraid and relatives aren't the best people to ask about the quality of care.

So many have dementia these days and so can't give their views and opinions. Unfortunately in my experience asking relatives about care doesn't work because relatives have different motives and they don't see much of the care given anyway. They may not care too much about how mom or dad is looked after [...] as long as they are in a home they are not a problem to them [...] that's why I think hidden cameras in care homes [...] well they don't have to be hidden, is such a good idea.

Other respondents suggested that as a result of the limitations of talking to residents arising from cognitive decline, and of consulting with their friends or relatives who visited the home, the use of closed circuit television monitoring systems was likely the only reliable mechanism that could serve to significantly reduce the likelihood of abuse occurring in the homes that they managed.

You cannot monitor good quality care into a care home ... you have got to have good care staff to start with

There was also evident recognition among the majority of respondents that the contract monitoring process, whether practised in the manners with which they were familiar or more effectively, could not fundamentally improve the quality of care and thus ensure the absence of abuse if the staff of the home did not value positively the people in their care:

The trouble with contract monitoring is that it's at the wrong end of the process as I see it. Well what I mean is no amount of monitoring is going to change the staff that you are managing and if these staff basically don't care about the old people in the home than they are not only going to fail to give them good care, but they are likely to treat them poorly, even abuse them [...] as we have seen on the television.

I don't think you can monitor good quality care into a care home. Maybe you can to a degree I suppose [...] but you can only do this if you have good care staff to start with [...] I mean staff who really care for the people they are to look after. If the care staff don't care, I mean don't regard the people in the care home as being of some worth or value still to society, then they won't look after them as they should. What you must remember is that there is no blood relationship between the people being looked after and the people doing the looking after and this has an influence. The influence comes in most I think when the work gets difficult [...] sad to say some of these old people can be very insulting and even aggressive and violent, especially if they don't understand what the staff are trying to do for them.

The problem with these so called quality teams is that they create a lot of resentment in the staff, some of who already don't care much for the people they are supposed to look after, so I don't think they can work too well. The staff have NVQs [National Vocational Qualifications] nearly all of them do but then someone from outside comes in and starts telling them what to do. This creates the resentment

y'know and when the quality people have gone that staff just do the things they were doing before anyway because the staff don't always care about these people. If I had my way I would get rid of most of these staff and get some that really do care [...].

The quality team from the local authority is just a temporary fix at best. If the staff don't actually value the old folks they look after they are not going to treat them well and will abuse them. I've seen it! It's a constant battle to get care staff to do what they are supposed to do. The problem lies beyond training, policies and procedures, and quality teams, it lies within the staff that you recruit. Quality teams can just make matters worse because staff are upset, their routines are upset.

The majority of respondents were clear in their perceptions that the personal evaluations held by care staff of the older people they were to look after were significant factors likely to contribute to the presence or otherwise of abuse. Care managers asserted that the personal evaluations formed by care staff of those in their care were not always positive and, as a result, efforts to improve quality and ensure the absence of abuse by means of training, policies and procedures and comprehensive care plans were largely futile.

Discussion

There was a clear perception among care managers participating in this research that the nature of current contract monitoring practice is far too superficial, concentrating on what Schein (2004) referred to as "organisational artefacts", that is, the written materials that are intended to influence the nature of care provided. Examples of these "artefacts" include written policies relating to conduct and care, records of training given to staff, and records relating to both the individuals and aggregates of individuals receiving care, predominantly in numerical formats, for example, the number of falls among residents. By concentrating scrutiny upon these artefacts, contract monitoring fails to penetrate the institutional façade often maintained by the staff of care and nursing homes when they are under scrutiny and therefore cannot determine the presence or absence of abusive acts and practices. That this is the case is supported by statistics demonstrating that a constant 36 per cent of safeguarding referrals have emanated from within care and nursing homes over five annual periods (The NHS Information Centre, 2012; The Health and Social Care Information Centre, 2014a, b, 2015; NHS Digital, 2016), the seminal research of Moore (2016a, 2017b) and the continued revelations of the abuse of older people residing in care homes captured irrevocably by concealed video recording devices in the hands of both undercover reporters and concerned relatives. Such incontrovertible evidence strongly supports a view that current methods of monitoring the performance of care home providers to the standards required within the contracts they hold with public agencies are failing extensively.

As respondents in this research all too readily pointed out, when abuse is perpetrated it is often behind the physical barrier to scrutiny that is the closed door of a bedroom, bathroom or toilet, or beyond the incorporeal impediment to "management" oversight that comes into being as darkness falls. With respect to the latter, not all proprietors and managers of care homes are even aware of the increased risk of abuse occurring at this time, though some may also be complicit with it, safe in the knowledge that the chance of any external observation of abusive practices occurring during the night is negligible. And of course, if proprietors and managers of care homes can sometimes remain unaware of abusive practices within their homes, how, as respondents in this research frequently asserted, can contract monitoring staff, particularly those who have never worked in care and nursing homes and who visit very infrequently, be expected to detect either the multitude of subtle and/or hidden means by which residents can be abused, or the elusive legacies of such abuse?

In short, they are unlikely to be able to, constrained as they often are by a lack of knowledge and experience and, irrespective of such deficiencies, hamstrung by methods of contract monitoring that are, in the opinions of respondents, superficial and naïve. Further, as the Care Services Improvement Partnership (CSIP) (2007, p. 9) asserted, the quality of care services that are purchased by public bodies can only be the "[...] highest quality achievable for the price paid". This often ignored factor relating to the purchase of care services by local authorities takes on greater significance when considering the fact that fees paid by them to private sector care and nursing homes nowadays are likely below what is economically viable, preventing providers from aspiring to ensuring high-quality care, reflected in the tenacity of levels of abuse as demonstrated

by the available statistics and recent research previously cited (The NHS Information Centre, 2012; The Health and Social Care Information Centre, 2013, 2014a, b, 2015; NHS Digital, 2016; Moore, 2016a, 2017b). Similarly, given the cost savings that local authorities have been required to make by central government in recent years, investment in the capacity and capability of their monitoring functions has likely not proliferated and developed in line with the expansion in the numbers of places in care homes that has occurred, an expansion that is set to continue as the population of older people who need such care grows, including many with dementia and multiple, complex, age-related pathologies (Her Majesty's Government, 2005; Franklin, 2014), unless alternative models of care are determined, which seems unlikely in the medium term.

Moreover, it is of some concern that a number of respondents expressed that though they recognised the superficiality of contract monitoring processes, they were untroubled by it because such a process was "[...] not demanding [...]" and gave them "[...] an easy life [...]" further suggesting an implicit recognition of the ease with which the façade of the care home remains largely unassailed by external agents. As several respondents from care and nursing homes in authority A pointed out, though contract monitoring had been moving towards a far greater emphasis on talking to people in receipt of care and their relatives a few years before the research here was conducted, this had been abandoned because of a change in management of the commissioning function, leading to a return to simplistic monitoring based on numerical data and a focus upon written records. Though there are clear difficulties associated with securing the perceptions of residents with more advanced dementia, and the perceptions of relatives and significant others must always be assessed with a generous measure of caution, contract monitoring based upon the experiences and perceptions of the people who are receiving care can only enlighten other, more superficial techniques of monitoring.

That consulting with those older people who receive care was recognised as having utility in assessments of the quality of a service and the absence of abuse was evident among respondents. However, there was a distinct division of opinion between respondents on how accurate and reflective of the real nature of residents' experiences the testimony of relatives could be, and this is recognised in the relevant literature (Godlove *et al.*, 2004; Joseph Rowntree Foundation, 2008; Age UK, 2011). Consequently, though the perceptions of the relatives and friends no doubt has some worth in the range of measures employed by local authorities in their contract monitoring efforts, it is apparent that caution is required when basing commissioning decisions upon them.

Yet, respondents also identified the significant number of residents in their care with dementia, whose resulting cognitive decline precluded them from recounting their experiences of the care they had received and their subjective judgements of its quality and the absence of abusive practices. This growing trend among the resident populations of older peoples' care homes, exacerbated by a tendency of many local authorities to facilitate the admission of only the most dependent of older people to care and nursing homes, thereby containing their expenditure, is yet to be overcome. Though the debate around the deployment of surveillance technologies, including the most contentious, the use of image recording devices in places where intimate personal care is most usually undertaken, continues, and Fisk (2015) and Padilla-Lopez *et al.* (2014) have provided useful discussion on the ethical dilemmas and practical difficulties, the issues remain unresolved. In the interim, however long that may be, the potential limited efficacy of current methods of contract monitoring revealed by this research needs to be brought to the fore as an important component of local authority commissioning activity. Only by doing so will the resources ever be made available to ensure that those who monitor contracts are not only appropriately experienced and skilled, but conduct their scrutiny more frequently and at times outside of usual "office hours".

Contract management is as intensive as any other public management function (Moore, 2002, p. 88; Cooper, 2003, p. 169), and contract monitoring activity should certainly not be left to inexperienced and unqualified personnel who have little or no experience of managing, and sometimes even working in, the services that they monitor. Not only should commissioners know what to buy and from whom, but they should also know exactly what they are buying (Kettl, 1993, p. 209); without the benefit of considerable experience in the field of actually providing and managing care, coupled with a lack of effective methodologies able to capture the lived experiences of

residents, contract monitoring staff are unlikely to be in a position to determine that what they see, be it on paper or occasionally in practice, is not what those in need of care are actually routinely receiving. Consequently, commissioners remain unaware that remedial actions are required to be enforced using the provisions of the contracts they have with care home providers, and periodic revelations secured by means of covert filming continue to be broadcast on television and through other visual media.

Furthermore, what is currently glaringly absent from contract monitoring processes, as recognised by respondents in this research, is any consideration of the fundamental personal value frameworks of the staff who provide care, either before, during or after the recruitment process (Kirkley *et al.*, 2011; Moore, 2017d). Though there has ostensibly been some attention given to the benefits of considering “values” in the recruitment and retention of staff who provide care (Skills for Care, 2013, 2017; Killeth *et al.*, 2013), to date, much of what are quoted as “values” as they relate to care staff are better described as “principles of care or of practice”, or are actually personal attributes that care staff may possess. For example, Skills for Care (2013, 2017) and Killeth *et al.* (2013, p. 99) cited the “values” of “dignity and respect”, “working together”, “commitment to quality support” and “leading by example” as desirable, yet these are examples of principles to be applied to providing care to others, or personal attributes of the staff who do so, and do not reflect how an individual staff member may value, either positively or negatively, the very people to whom these principles of care and personal attributes should be applied (Moore, 2017d; Jimenez, 2009). Care staff who positively value the vulnerable older people in their care are the very bedrock of ensuring care home environments are free from abuse as those who have managed the provision of care will know.

Conclusions

Recent guidance from the Department of Health (2017) on the implementation of the Care Act 2008 clearly identifies that the protection of people from abuse and neglect as a means of promoting their wellbeing is a duty incumbent upon local authorities (paragraphs 1.5 and 4.102), and instructs them to promote quality services through their contracting functions (paragraph 4.0).

However, over the intervening decades since the inception of the NHS and Community Care Act 1990, a plethora of policy documents and assertions that have emanated from agents working on behalf of government, charitable organisations and academics, have perpetuated an illusion that current methods of monitoring the performance of private sector care homes are credible, serve to enhance the quality of care in care homes and prevent abuse. Yet, both the available numerical data and recent research into the extent of abuse that still endures in care homes begin to cloud the clarity of this view, confirming that abuse continues at a constant level, remains undetected despite the activity of those who monitor contracts, and is sometimes actively and effectively concealed (Moore, 2016b; Greve, 2008). In part, this may be because the guidance and methodologies available to commissioners are often at best ill-founded and overly simplistic, at worst, utterly naïve, and fail to acknowledge, identify and address any of the fundamental causes of abuse.

These circumstances have endured for many years, and are brought into stark relief by, for example, the overly simplistic application to care homes of the “six principles of care” devised by government as detailed within “Safeguarding and Quality Commissioning in Care Homes” (Social Care Institute for Excellence, 2012). These six principles of care are “empowerment”, “protection”, “prevention”, ‘proportionate responses, “partnership” and “accountability”. Yet, first, the gamut of research that is available demonstrating that the vast majority of both older and younger people would prefer to remain at home for as long as possible, and be supported in this choice during periods of illness and increasing dependence as they age, immediately undermines the principle of “empowerment” as it may be applied to older people consigned to care and nursing homes (McCafferty, 1994; Warburton, 1994; Leather and Sykes, 1995, p. 31; Forrest *et al.*, 1997, p. 6; Tinker, 1997, p. 110; Department of Health, 1998, p. 2/7, 2009b, p. 6; Hayden *et al.*, 1999, pp. 63/87; Tinker *et al.*, 1999, 2000, p. 53; Commission for Social Care Inspection, 2004, pp. 3-7; Audit Commission, 2004a, p. 6; Audit Commission, 2004b, p. 14; Poole 2006, p. 16; Yeandle, 2009, p. 32; Katz *et al.*, 2011). If individual older people were truly

empowered, the majority of the estimated 300,000 older people currently in UK care homes (Office for National Statistics, 2017) would not be there, they would be at home. Second, the failures of ever increasing amounts of training for care home staff, of continued regulation, and of multi-agency safeguarding responses, to reduce the constancy with which abuse occurs in care homes for older people (Moore, 2016a, 2017b) and the ceaseless additions to the existing catalogue of abuse amassed over the decades, much of it nowadays captured by covert filming, similarly challenges the credibility and effectiveness of the vaunted principles of “protection”, “prevention”, “proportionate responses”, “partnership” and “accountability” as applied to the activities of both commissioners and care homes for older people alike.

Clearly, unless the fundamental causes of the poor care and abuse that clearly persists can be identified and addressed, abuse in care and nursing homes will continue. In the meantime, the monitoring of contracts by local authority commissioners and their counterparts in the NHS could have a role in deterring, detecting and possibly remedying abusive practices and actions. But it is apparent from this limited research that methods of contract monitoring, and some of the personnel employed by local authorities to undertake this function, must be rendered more effective to penetrate the façade, the fog, that obscures the reality of what really happens routinely in some care homes with alarming regularity.

Notes

1. Commissioning is the process of identifying needs for care and support services within a population and of developing policy, service models and the market to meet those needs. Contracting and contract monitoring are functions within commissioning that are concerned with the technical aspects of contracts and the monitoring of the quality of what is provided under the terms of those contracts.
2. The changes as a result of the Act were introduced incrementally, first from April 1991 and subsequently from April 1990.
3. A Kennedy Terminal Ulcer is a specific type of pressure sore that is characterised by rapid onset and rapid tissue breakdown, sometimes in a matter of hours.

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