Number 2
73 Editorial
78 Learning from safeguarding adult reviews on self-neglect: addressing the challenge of change
Michael Preston-Shoot
93 Reporting sexual violence on mental health wards
Marian Foley and Ian Cummins
101 The sexual street harassment battle: perceptions of women in urban India
Jehangir Bharucha and Rita Khatri
110 Through a glass darkly: exploring commissioning and contract monitoring and its role in detecting abuse in care and nursing homes for older people
Steve Moore
128 Book review
Welcome to our second issue of this year. As always, there are lots of events to snag the attention of safeguarding students – violence in all its manifestations, belated convictions, the bonuses of the overpaid and organisations caught in the headlights because they did not protect children and young people and adults with support needs. There are too many trials being described as “the biggest […] abuse scandal”. So, we will begin with a rare account of a successful and concerted initiative, to reduce knife crime. “No knives, better lives[1]” was part of the Scottish Government’s response to Scotland’s significant knife crime problem. The Strathclyde Police set up a specifically funded Violence Reduction Unit, which has adopted a public health approach to knife crime, that is, the police undertake focussed work with the health, education and the social work services. From stop and searches, hard-hitting campaigns, increasing sentences for carrying knives in Scotland and hearing victims and their relatives describe the impacts of knife crimes on them, in court – Scotland has significantly reduced the numbers of children and teenagers killed.

Another programme of work merits consideration. Two years ago, the Mersey Care Trust set itself the goals of reducing re-admissions for self-harm and eliminating suicides[2]. Mental health patients’ social media posts are scanned by an artificial intelligence app for signs and cues that they may be contemplating harm or suicide and it alerts services when they visit suicide hotspots. While perhaps not as exhilarating as the precision and miniaturisation of robot-assisted remote surgery, for example, the outcomes are just as valued.

Back to the usual fare, we begin with the trial of Larry Nassar, a world-renowned Sports Physician, who has just begun his 175-year sentence for decades of sexually abusing girls and young women who aspired to be Olympian athletes. More than 150 women made impact statements[3]. Complaints about him were dismissed. He convinced parents that their children were lying. It is inexplicable that his night time “pelvic exams” in hotels and dormitories went unchallenged. USA Gymnastics, Michigan State University and the US Olympics Committee took no action.

Onto football and one junior football coach, youth scout and predatory paedophile’s legacy will not be forgotten at Chelsea, Crewe Alexandra and Manchester City. Since Barry Bennell was also associated with junior teams in Derbyshire, Staffordshire, Cheshire and Greater Manchester and “soccer camps” in the USA, the reach of his crimes is unknown[4]. A series of convictions in the USA and UK did not halt his crimes. A “star maker” – it is not only the patriarchy of filmmakers who deploy sexual aggression to selectively advance the careers of chosen victims. Just as #MeToo revealed the courage required by young women in a single industry to reveal the dark underbelly of criminal assaults and threats, children and young boys did not asked to be raped. Bennell has been jailed for 31 years.

Bijan Ebrahini was a disabled Iranian refugee who will not be quickly forgotten by Avon and Somerset Police and Bristol City Council[5]. They treated him as a nuisance and troublemaker rather than a complainant reporting multiple crimes committed against him. He was arrested on 15 occasions and yet was never prosecuted. He was kicked to death and a neighbour, Lee James, who had believed Ebrahini was a paedophile, set his body on fire. The failures of the police and council resulted in the findings of police racism at both officer and institutional levels. He was “treated differently to his detriment and without objective reason”. Four police officers were dismissed, two of whom received jail sentences – two decades after the publication of the MacPherson report concerning the racist murder of Stephen Lawrence and the institutional racism that was prevalent at that time.
Meanwhile, the festival of greed persists uninterrupted with chief executives immune to embarrassment. For example, the taxpayer-backed help-to-buy scheme has made some builders very rich[6]. The Chief Executive of Housebuilder Persimmon has received a “bonus” of £100 m – linked to stock market performance, which was boosted by the taxpayer-backed scheme.

The Community Security Trust reported an increase of 3 per cent in anti-Semitic incidents during 2017[7]. The total of 1,382 incidents is attributed, inter alia, to “the rise in all forms of hate crime following the referendum to leave the European Union in June 2016”. The most common form of incident was randomly directed verbal abuse in public. The theme for Holocaust Memorial Day 2018 was “The power of words”.

We know that mistakes, trial and error are vehicles to learning. However, doctors are threatening to cease recording their errors in the wake of Hadiza Bawa-Garba’s conviction of manslaughter by gross negligence[8]. The conviction hinged on the death of six-year-old Jack Adcock in 2011. Jack had Down’s syndrome. Bawa-Garba did not diagnose sepsis, or escalate his deterioration to a consultant. She mistakenly halted his resuscitation. There is, however, a view that the doctor is a scapegoat for systemic failings and possible racism.

However, mistakes, trial and error may not always be effective vehicles to learning. Some readers will have been following the torturous tale of Connor Sparrowhawk, who died in a bath in an Assessment and Treatment unit in July 2013, as a result of an epileptic fit. The Consultant Psychiatrist in the Unit, Dr Valerie Murphy, who is currently working in Ireland, has been subject to a GMC hearing into her fitness to practice, which was finally drawn to a conclusion in mid-February. Some of the delay in hearings and outcomes has been due to deliberations by the GMC concerning Dr Murphy’s apparent failure to acknowledge her role and level of responsibility for what happened to Connor and her absence of insight about both the situation and her role in it. The final determination by the GMC, issued in mid-February is that Dr Murphy has been suspended from the GMC register for a period of 12 months from late March this year, with a further review at the end of this time to determine if she can be re-admitted to the register. Readers will have seen a book review (by Margaret Flynn) of Justice for Laughing Boy, written by Connor’s mother, Sara Ryan in the previous issue of the journal and be aware of the ongoing stress and distress that the family face. This outcome may not serve to alleviate the distress that much.

Belated justice was realised during January 2018 when harpist Danielle Perrett and her ex-partner were found guilty of sexually assaulting a 14-year-old boy more than 30 years ago[9]. Richard Barton Wood was the boy’s Teacher and he had assaulted the boy on several occasions prior to taking him to spend the night with him and his fiancée. Despite apparent attempts by the couple to deflect attention away from them, and to implicate a “promiscuous teenager”, the court found both parties in the couple culpable of sexual assault.

The public inquiry into historical child sexual abuse has been scaled back[10]. It will undertake to assess how organisations responded to abuse claims rather than investigating claims of an establishment cover-up and whether or not allegations against Westminster figures are true, which was one of the perceived strengths of the inquiry. The Times reported that since 2015 until this most recent decision, it has cost £56.2 m (O’Neill, 2018).

At the end of 2017, Lord Carlile criticised the Church of England for its “rush to judgement” in handling allegations of sexual abuse against George Bell, the former Bishop of Chichester who died in 1953[11]. At the beginning of February 2018, the Archbishop of Canterbury was criticised by historians for stating that there was a “significant cloud” over George Bell[12]. The Archbishop declined to rescind the claim, observing that:

> Our history over the last 70 years has revealed that the church has covered up, ignored or denied the reality of abuse on major occasions […] As a result, the church is rightly facing intense and concentrated scrutiny.

A former headmaster of St Benedict’s School, who became the abbot of west London’s Ealing Abbey before going on to work at the Benedictine headquarters in Rome, was found guilty of rape and other sexual offences at the end of 2017. Andrew Soper[13] also subjected pupils to
sadistic beatings. Soper had withdrawn money from Vatican bank accounts and became a fugitive in Kosovo. He was sentenced to 18 years.

In the early months of this year, we have also heard about the trial of Matthew Falder, a former Lecturer in Geophysics and Cambridge graduate who was described as a “warped and sadistic” paedophile, who blackmailed victims and shared abuse tips and images on the dark web. During his trial, Falder admitted 137 charges, including rape, against 46 people, some of whom attended his court hearing. Through his use of blackmail, victims were coerced into various acts of degradation, including licking toilet seats and self-harming. Falder was eventually caught after several years by an international global taskforce, involving security services from Europe, the USA, Australia, New Zealand and Israel due to his involvement in the “dark web”. And in a very rare step, the University of Cambridge has indicated that it is “actively pursuing” stripping Falder of his academic qualifications. Falder has been jailed for 32 years, with a further six years on licence on his release. Several of his victims have stated that they are also serving life sentences as a result of his abusive actions[14].

Once again, home education is at centre stage. California parents David and Louise Turpin have been charged with torture and child endangerment after their 13 severely malnourished children were rescued. Seven of the Turpins’ legally adult children did not appear to be so because of their physically compromised condition[15].

Early February saw the publication of a Safeguarding Adults Review (SAR) on a care home run by the National Autistic Society (NAS), Mendip House in Somerset[16]. Residents of the care home were subjected to bullying, humiliation and “cruel behaviour” by the staff in ways that appear alarmingly reminiscent of events that took place at Winterbourne View private hospital some years ago. The review report stated that there was a group of controlling male staff, which had dominated the home; eventually five staff members were dismissed. The home closed in the autumn of 2016 around five months after several whistleblowers had made reports to the CQC. The review determined that the NAS was “primarily accountable and responsible” for the abuse that took place in the home. Funding for the home predominantly came from Somerset Clinical Commissioning group, but seven different local authorities were involved in relation to placements of the small number of residents. It appears that an earlier report had indicated that concerns might have been addressed sooner if fewer authorities had been involved. The review report recommended that there should be changes to the way that care placements are managed, including the almost obvious conclusion that commissioners (in the form of clinical commissioning groups and local authorities) must monitor placements and quality of care effectively. Once more it seems that concerns are raised about remote commissioning and the inadequacy of the review system for distant placements – with a striking and conspicuous need for renewed and increased scrutiny. When will this increasingly critical situation be resolved?

Finally, the charities – and we have glimpsed some terrible secrets. In late January 2018, we heard of a “Presidents Club Charity[17]” for captains of industry. Specifically, there was a men-only fundraising dinner at which 130 hostesses were groped and propositioned, having been asked to sign five-page, non-disclosure documents. Organisations have since said that they do not want donations tainted by such entrenched sexism, but there are pressures in such austere and cash strapped times[18]. Onto Haiti, and Oxfam is not the charity we imagined[19]. Post-earthquake allegations of sexual exploitation by aid workers during 2010 are shocking, the consequences of which continue to evolve. Once again, some much-needed space is being given to those who experienced assaults and threats – but this is very belatedly – once again.

This issue of the journal contains a number of papers about different aspects of safeguarding; from care homes to mental health trust hospitals and community-dwelling people who experience abuse and/or neglect. Our first paper is by Michael Preston-Shoot and is a further paper based on additional research on the issue of self-neglect. The paper considers the issue of self-neglect within SARs, which some readers will be familiar with from previous papers written by Michael and his colleagues. One aim of the paper is to update the database that has been developed about safeguarding adult reviews that focus on self-neglect and accompanying
thematic analysis. Additionally, however the paper examines what components might be needed to move from action plans to changes in both policy and practice, where necessary. Several additional published reviews are therefore added to the core database that has been established and the thematic analysis that was previously developed, that contains four domains, is also updated in the paper. Further to this a framework for how to take action plans developed from the findings and recommendations from SARs in this area is introduced to enable Safeguarding Adults Boards (SABs) to ensure longer-term and strategic approaches to changes in policy and practice. This will be useful to those readers who are involved in work around both SABs and SARs but also to others who are interested in the overall evolution of safeguarding practice and policy development in this area.

Our second paper of the issue, by Marion Foley and Ian Cummins, focuses on the issue of sexual violence within mental health settings. The paper reports on the findings of a scoping study on the extent of recorded sexual violence of inpatients on mental health units. The study used Freedom of Information requests to local police forces and mental health Trusts to obtain information about recorded incidents of rape and sexual assault (by penetration) over a five-year period. The results indicated that there were significant variations in how such incidents were recorded by police forces and Trusts and that practices were inconsistent and inadequate. The resulting information gap also suggests that individuals with a history of in-patient mental health events may be less likely to have sexual assaults investigated or recorded as a crime. A number of recommendations to address this problem are made in the paper.

The third paper by Rita Khatri and colleagues from India is also related to sexual violence and concerns sexual harassment at street level of women in Mumbai. The paper is based on a research study that aimed to explore the issue of women’s safety on the streets of Mumbai. Methods used in the study included the combination of use of a structured survey, in-depth interviews and an audit of busy street areas by the researchers, considering a number of aspects that might affect the safety of women in these places. The findings included strong views about transport safety, perceptions, personal experiences and difficulties in relation to police involvement. The overwhelming majority (over 90 per cent) of the study respondents indicated concern and anxiety about safety most or all of the time when outside the home. A number of useful recommendations for future developments relating to safety are made in the paper.

The final full paper is by Steve Moore and is a further paper from him about elder abuse in care home settings. The specific focus of this paper extends his examination of commissioning practices, with this study concerning the perspectives of care home managers about the role of contract monitoring (external to the homes) in preventing abuse. A number of semi-structured interviews were held with the managers of 16 care homes in one area of England (two local authorities). Although care home managers usually regarded individuals involved in contract monitoring quite positively personally, they were perceived as relatively ineffective due to lack of knowledge about and experience of care provision. The results of the research imply that currently, contract monitoring may be of limited use in effectively establishing the nature of care provided in care homes, or potentially the presence of abuse. There are links too to some of the issues raised earlier in this editorial in relation to the findings from the SAR of Mendip House.

Our final offering of this issue is a book review by Neil James covering the second edition of Safeguarding Adults in Nursing Practice, written by Ruth Northway and Robert Jenkins. Although the book is aimed at student nurses, it will be of interest to practitioners from a number of different disciplines and aims to increase knowledge and understanding of practice, policy and research in safeguarding. Since books on developing practice in safeguarding are relatively thin on the ground, it is good to see publication of this second edition.

We hope that the range of articles in this issue will provide much of interest for readers. As ever, we are keen to publish work that is taking place in this broad area, across research, policy and practice and to encourage contributions from authors. If anyone has any ideas for papers for future issues and wishes to discuss these further, please do get in touch with one of the editors (Margaret Flynn and Bridget Penhale). Our contact details appear on the cover of the issue.
Notes

2. www.thetimes.co.uk/article/app-can-spot-patients-close-to-suicide-0xf58mcx0
4. www.bbc.co.uk/news/uk-38104681
5. www.bbc.co.uk/news/uk-england-bristol-42393488
8. www.pulsetoday.co.uk/your-practice/regulation/gmc/bawa-garba-timeline-of-a-case-that-has-rocked-medicine/20036044.article
10. www.bbc.co.uk/news/uk-42892312
13. www.bbc.co.uk/news/uk-england-london-42257548
17. www.ft.com/content/075d679e-0033-11e8-9650-9c0ad2d7c5b5
18. www.ft.com/content/075d679e-0033-11e8-9650-9c0ad2d7c5b5

Reference

Learning from safeguarding adult reviews on self-neglect: addressing the challenge of change

Michael Preston-Shoot

Abstract
Purpose – The purpose of this paper is to update the core data set of self-neglect safeguarding adult reviews (SARs) and accompanying thematic analysis, and to address the challenge of change, exploring the necessary components beyond an action plan to ensure that findings and recommendations are embedded in policy and practice.

Design/methodology/approach – Further published reviews are added to the core data set from the websites of Safeguarding Adults Boards (SABs). Thematic analysis is updated using the four domains employed previously. The repetitive nature of the findings prompts questions about how to embed policy and practice change, to ensure impactful use of learning from SARs. A framework for taking forward an action plan derived from an SAR findings and recommendations is presented.

Findings – Familiar, even repetitive findings emerge once again from the thematic analysis. This level of analysis enables an understanding of both local geography and the national legal, policy and financial climate within which it sits. Such learning is valuable in itself, contributing to the evidence base of what good practice with adults who self-neglect looks like. However, to avoid the accusation that lessons are not learned, something more than a straightforward action plan to implement the recommendations is necessary. A framework is conceptualised for a strategic and longer-term approach to embedding policy and practice change.

Research limitations/implications – There is still no national database of reviews commissioned by SABs so the data set reported here might be incomplete. The Care Act 2014 does not require publication of reports but only a summary of findings and recommendations in SAB annual reports. This makes learning for service improvement challenging. Reading the reviews reported here enables conclusions to be reached about issues to address locally and nationally to transform adult safeguarding policy and practice.

Practical implications – Answering the question “how to create sustainable change” is a significant challenge for SARs. A framework is presented here, drawn from research on change management and learning from the review process itself. The critique of serious case reviews challenges those now engaged in SARs to reflect on how transformational change can be achieved to improve the quality of adult safeguarding policy and practice.

Originality/value – The paper extends the thematic analysis of available reviews that focus on work with adults who self-neglect, further building on the evidence base for practice. The paper also contributes new perspectives to the process of following up SARs by using the findings and recommendations systematically within a framework designed to embed change in policy and practice.

Keywords England, Change, Self-neglect, Care Act 2014, Action plans, Safeguarding adult reviews

Paper type Research paper

Introduction
The cases of adults who self-neglect continue to challenge practitioners, the agencies for which they work, and Safeguarding Adults Boards (SABs). One thematic review of safeguarding adult reviews (SARs) (n = 27), commissioned and completed by SABs in the London region between April 2015 and April 2017, found that 33 per cent centrally involved self-neglect (Braye and Preston-Shoot, 2017). A second thematic review (Preston-Shoot, 2017a), of serious case...
reviews (SCRs) and SARs commissioned and completed by SABs in the South-West region between January 2013 and July 2017 \( n = 37 \), found that 32 per cent centrally involved self-neglect. Both thematic reviews also contained reviews where self-neglect combined with other forms of abuse and neglect, adding further complexity.

Previous analyses of reviews involving self-neglect have identified the complexities, dilemmas and challenges for practitioners, agencies and multi-agency partnerships, and highlighted the components of effective adult safeguarding (Braye et al., 2015a, b; Preston-Shoot, 2016, 2017b). However, the on-going prominence of self-neglect cases amongst the SARs commissioned by SABs, and the similarities within their findings, invites further scrutiny into the facilitators and barriers for effective practice across adult safeguarding systems – organisations, inter-agency working and the financial, policy and legal context within which SABs and their partners function. It also invites enquiry into how SABs and their partner agencies approach the challenge of change, translating and then embedding review findings and recommendations into effective arrangements for direct practice with adults who self-neglect.

This paper, then, has two objectives. The first is to update the database on SARs involving self-neglect and to refresh the learning available from them. The second is to review how SABs are approaching the challenge of change and to develop strategies for impactful use of SARs.

Methodology

All SAB websites in England were accessed in Autumn 2017 and published SARs read for references to self-neglect. Some unpublished SARs were retrieved from one thematic review (Braye and Preston-Shoot, 2017) and through personal contacts with SAB independent chairs and business managers. The same analytic approach is used here as previously (Braye et al., 2015a, b), with case numbering continuing the database sequence (Preston-Shoot, 2017b). Thus, the initial analysis explored the key characteristics of each case and of each review followed by the frequency of different types of recommendations and the themes within them. Subsequently, a four-domain approach was used to organise the themes extracted from reading review findings, with a focus on identified good practice as well as learning for change.

Proposed regional and/or national repositories may make it easier for SABs and their partner agencies to learn from experience elsewhere. Currently, however, learning remains largely localised and it is time consuming and sometimes challenging to track down SARs.

Layer 1: case characteristics

In the complete sample \( n = 134 \), where gender is known and noting in some cases the presence of more than one person, men outnumber women (74/58), with one person reported as transgender. The largest age group remains people aged over 76 (24 per cent), followed by those aged 40-59 (23 per cent) and those aged 60-75 (19 per cent). Age is withheld in just over a quarter of cases. Ethnicity is rarely recorded as found also in other thematic appraisals of SARs (Braye and Preston-Shoot, 2017; Preston-Shoot, 2017a). Within this sub-sample and across the sample as a whole, refusal of services \( n = 23 \) and 81) and lack of self-care \( n = 24 \) and 78) are more prominent, and often combined in cases, than lack of care of one’s environment \( n = 2 \) and 34). All three components of self-neglect are present in seven cases within this sub-sample and 41 cases overall. Prominent too within the reviewed cases are scenarios where alcohol and/or drug abuse are accompanied by financial and physical abuse by third parties (Table I).

Layer 2: key characteristics of the SAR

Within this sub-sample, self-neglect is usually the central focus rather than implicit or peripheral. Across the whole sample \( n = 134 \), where information is available, it is the central focus in 59 per cent of cases, implicit in 24 per cent and peripheral in 12 per cent. Once again, various
methodologies have been employed, although in this sub-sample the traditional approach of the independent management reviews, combined chronology and panel deliberation appears less common than a hybrid approach involving a systemic orientation that also uses learning events and/or interviews. This trend has also been noted in thematic reviews of completed SARs (Braye and Preston-Shoot, 2017; Preston-Shoot, 2017a). Within this sub-sample, most reviews (27/34) contain ten or fewer findings/recommendations, replicating a trend towards fewer priority actions noted elsewhere (Preston-Shoot, 2017a) (Table II).

Layer 3: recommendations

Within this sub-sample, recommendations are most commonly directed to a Safeguarding Adult Board (33 SARs) but adult social care (6), housing (5) and NHS trusts (5) appear regularly. There are occasional recommendations for GPs, pharmacists, police, ambulance trusts, public health, local authority commissioners and clinical commissioning groups. Four reviews make recommendations to all the SAB’s partner agencies. Increasingly recommendations are being directed to the SAB alone (20 cases in the sub-sample), allocating to it the responsibility for ensuring an action plan is implemented, with policy and practice reflecting fully the review’s conclusions. The specific involvement of other agencies as parties to the recommendations, such as Adult Social Care and the police, is contained within this approach (case 112 is an example).
Some reviews reference recommendations offered by agencies as part of IMRs and/or reflective interviews. Cases 116, 117, 121, 130, 132 are examples where the precise nature of the recommendations is not specified, arguably undermining the quality marker of transparency. Cases 111, 123, 125 and 127 offer examples where agency nominated recommendations are explicitly listed. Some evidence emerges of SABs requesting a limited number of SMART recommendations, locally focused (case 115 is an example). Occasionally reviews identify

<table>
<thead>
<tr>
<th>Case number</th>
<th>Published, type, length</th>
<th>Methodology</th>
<th>Self-neglect focus</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>101</td>
<td>Published, SAR, 57 pages</td>
<td>IMRs, chronology and panel</td>
<td>Central</td>
<td>9</td>
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<td>102</td>
<td>Published, SAR, 32 pages</td>
<td>IMRs and chronology</td>
<td>Central</td>
<td>9</td>
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<tr>
<td>103</td>
<td>Not published, SAR, 50 pages</td>
<td>SCIE</td>
<td>Central</td>
<td>11 findings</td>
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<tr>
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<td>SCIE</td>
<td>Central</td>
<td>3 findings, 6 recommendations</td>
</tr>
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<td>105</td>
<td>Not published, SAR summary, 3 pages</td>
<td>Learning review</td>
<td>Implicit</td>
<td>3</td>
</tr>
<tr>
<td>106</td>
<td>Published, SAR, 31 pages</td>
<td>IMRs, chronology but not fully specified</td>
<td>Central</td>
<td>6</td>
</tr>
<tr>
<td>107</td>
<td>Not published, SAR, 33 pages</td>
<td>Chronologies, panel and agency enquiries</td>
<td>Implicit</td>
<td>10</td>
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<tr>
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<td>Published, SAR executive summary, 7 pages</td>
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<td>Central</td>
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<td>Published, SAR, 9 pages</td>
<td>Meeting sphere</td>
<td>Implicit</td>
<td>10</td>
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<tr>
<td>110</td>
<td>Published, SAR, 54 pages</td>
<td>Hybrid – learning event and chronologies</td>
<td>Central</td>
<td>23</td>
</tr>
<tr>
<td>111</td>
<td>Published, SAR, 52 pages</td>
<td>Hybrid – learning events, reflective questions and chronologies</td>
<td>Central</td>
<td>28</td>
</tr>
<tr>
<td>112</td>
<td>Published, SAR, 14 pages</td>
<td>Hybrid – learning meeting, chronologies</td>
<td>Central</td>
<td>3 findings, 6 recommendations</td>
</tr>
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<td>113</td>
<td>Published, SAR, 44 Pages</td>
<td>SCIE</td>
<td>Central</td>
<td>6 priority findings</td>
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<td>SCIE</td>
<td>Central</td>
<td>5 findings</td>
</tr>
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<td>Hybrid</td>
<td>Central</td>
<td>3</td>
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<td>Published, SCR, 62 pages</td>
<td>IMRs and chronologies</td>
<td>Central</td>
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<td>117</td>
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<td>Hybrid – learning event, interviews, chronologies</td>
<td>Central</td>
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<td>Summary of learning from other cases and chronology</td>
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<td>2 and single agency recommendations</td>
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<td>IMRs and chronologies</td>
<td>Peripheral</td>
<td>4</td>
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<td>124</td>
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<td>Implicit</td>
<td>5 themes, 3 recommendations</td>
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<tr>
<td>125</td>
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<td>Implicit</td>
<td>9</td>
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<td>Published, learning together adult review, 7 pages</td>
<td>SCIE</td>
<td>Implicit</td>
<td>7 findings</td>
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<td>Published, SAR, 46 pages</td>
<td>IMRs</td>
<td>Implicit</td>
<td>8 and individual agency IMR recommendations</td>
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<tr>
<td>128</td>
<td>Published, SAR, 31 pages</td>
<td>SCIE</td>
<td>Central</td>
<td>4 findings</td>
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<td>129</td>
<td>Published, SAR, 39 pages</td>
<td>IMRs and chronologies</td>
<td>Implicit</td>
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<tr>
<td>130</td>
<td>Published, SAR, 19 pages</td>
<td>IMRs</td>
<td>Implicit</td>
<td>8</td>
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<tr>
<td>131</td>
<td>Published, SAR, 39 pages</td>
<td>SCIE</td>
<td>Central</td>
<td>4 findings</td>
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<tr>
<td>132</td>
<td>Published, SAR, 75 pages</td>
<td>Hybrid – IMRs, chronologies, learning event</td>
<td>Central</td>
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<td>Hybrid – chronology, document review, learning event</td>
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<td>8</td>
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<td>Published, SAR, 32 pages</td>
<td>Hybrid – IMRs chronology, practitioner event</td>
<td>Central</td>
<td>10</td>
</tr>
</tbody>
</table>

Note: *Although the case met the statutory criteria for an SAR, on grounds of proportionality, due to the learning already available locally and more widely from self-neglect cases, a summary of learning was constructed*
changes already implemented (case 116 is one instance), perhaps conscious of Wood’s (2016) challenge that little is being learned from cases.

Across the entire sample \((n = 134)\), 74 per cent of SARs make recommendations to a SAB and 42 per cent to Adult Social Care. NHS trusts received recommendations in 26 per cent of cases, clinical commissioning groups in 23 per cent, Housing in 18 per cent, GPs in 14 per cent and the police in 10 per cent. Occasionally, other uniformed services, care agencies, third-sector agencies and children’s services are named, reflecting again that safeguarding is everyone’s business.

There remain reviews where recommendations do not specify the agencies towards which they are directed (six in this sub-sample). As previously observed (Braye et al., 2015a), this potentially complicates the construction of action plans and the subsequent evaluation of the impact of learning.

Layer 4: themes within recommendations

Four broad categories of recommendations are retained – staff support, review process, best practice and procedures (Braye et al., 2015a). Within the sub-sample, 17 reviews recommend training and 7 improvements to supervision and support. Across the full sample, 59 per cent of reviews contain recommendations regarding training and 34 per cent supervision, including access to specialist advice. The considerable faith is placed in training without explicit attention to workplace development alongside workforce development (Braye et al., 2013) to ensure that the staff can embed in practice what they have learned.

This sub-sample contains fewer concerns about how the review process unfolded and was managed; three SARs contain recommendations here, designed for example to improve the adequacy of IMRs and the management of serious incident investigations. Of greater concern appears the importance of learning from reviews, with 12 recommendations about dissemination locally and nationally. Although it now appears expected that SABs will construct action plans once an SAR has been accepted, eight reviews contain specific recommendations regarding the content and subsequent use to be made of them. Across the whole sample, 22 per cent of reviews contain recommendations regarding action planning, 21 per cent about future management of the review process and 30 per cent about using the report for learning and service development.

Within the best practice theme in this sub-sample, mental capacity assessments drew 11 recommendations, including the importance of exploring people’s choices, unravelling the notion of lifestyle choice and identifying desired outcomes from risk assessments. There were recommendations about person-centred, relationship-based approaches and about different ways of seeking to engage with people who are refusing services in 16 reviews. Three SARs contained recommendations concerning knowledge and use of the law, and seven on assessment and involvement of family carers. Across the entire sample, best practice in mental capacity assessments dominates the picture; 39 per cent of reviews contain recommendations here. Mindful of the challenges of working with adults who self-neglect, 29 per cent of reviews contain recommendations concerning engagement and 28 per cent remind practitioners and managers of the importance of relationship-centred practice. The relationship focus extends to family members; 22 per cent of reviews highlight assessment of carers and understanding family dynamics. In total, 16 per cent of SARs contain recommendations about legal literacy.

Recommendations continue to place faith in procedures. Within the sub-sample, 24 SARs recommend the development and/or review of guidance, for example, on escalation of concerns and information sharing as well as self-neglect itself. In total, 12 focus on referral and assessment and 26 on case management, including the use of section 42 enquiries, safeguarding or self-neglect pathways and reviews. Recommendations regarding working together occur in 25 cases, information sharing in 17. In total, 11 cases refer to the importance of recording. Across the whole sample \((n = 134)\), 71 per cent of SARs recommend the development and/or review of guidance for staff; 62 per cent focus on referral and assessment pathways. In all, 58 per cent make recommendations regarding inter-agency working, whilst
56 per cent focus on case management (including care planning, reviews, quality audits and escalation of concerns). Recommendations regarding recording occur in 40 per cent of cases, information sharing in 43 per cent.

**Cross-case analysis**

Four domains, now, explore the themes emerging from this sample of reviews.

*Domain A: practice with the individual adult*

As evidenced previously (Preston-Shoot, 2016, 2017b), the importance of considering and responding to repeating patterns is highlighted (106, 111, 127). Two cases (120, 121) observe that each referral episode was viewed in isolation rather than in the context of foregoing history. Reviews also continue to advise a “think family” approach, with liaison with children’s services when indicated (103, 114). Family members (and neighbours) may hold information that might help practitioners to appreciate what is causing or maintaining self-neglectful behaviour, including a reluctance to accept help (101, 105, 106, 111, 112, 121). Practitioners need to engage with family members who provide support, especially when they are requesting help (109, 115, 116, 123). Equally, however, there may be complex co-dependent dynamics between caregivers and those they are caring for perhaps involving abuse and neglect (120, 125, 126, 133). Carer’s assessments should be offered and be thorough, exploring mixed messages about giving care and support, willingness and ability to cope, and any evidence of difficulties and neglect (103, 106, 109, 125, 134). However, practitioners must speak with the adult who self-neglects as the (hostile) presence of another person can affect their engagement (117, 118, 124, 127).

Tension between autonomy and duty of care remains a prominent theme, with multi-agency meetings seen as crucial to discuss differences of opinion between professionals, evaluate options and avoid defensive practice (108, 113, 115, 122, 128, 130-132, 134). Several cases emphasise the importance of persistent offers of support, respectful challenge and updated risk assessments (102-104, 109, 120, 129). Links are made here with exploring executive capacity (105, 106, 114) as individual agency and choice may be more compromised than practitioners appreciate.

Criticisms of mental capacity assessments continue. Cases (101, 107, 110, 115, 129) criticised practitioners for failing to record for which decisions the individual was assessed as having capacity and/or to consider the impact of impairment of executive brain function. Elsewhere capacity was assumed (106, 108, 111, 117, 120-122, 127, 129, 132). Sometimes assessment was insufficiently robust, perhaps because practitioners lack confidence in their knowledge and skills, and in taking best interest decisions (113, 125, 133, 134). Assessment must be contextual, cognisant of relationships surrounding the individual (103, 124) and include triangulation with the known information, for example, a person’s mental health history (103, 114, 120). The failure to involve advocates also emerges (106, 110, 120, 127, 129).

On non-engagement, a key message is to express concerned curiosity about possible explanations. Simply sending letters, expecting individuals to respond positively to clinic/office appointments, and closing the case when no response has been received is insufficient (103, 106, 111, 114, 116-118). Using different strategies to engage following missed appointments and monitoring cases through documented multi-agency meetings or “at risk pathways” are advised (103, 117, 120, 122, 126, 127, 129).

A person-centred, relationship-based approach is emphasised to establish trust, appreciate the reasons behind self-neglect, explore perspectives and preferred options, offer support and wherever possible negotiate interventions (101, 106, 116, 129, 131, 132). A person-centred approach should not exclude the expression of concerned curiosity or inquisitorial questioning (107, 118, 134). It does not mean avoiding difficult conversations, including respectful challenge of decisions (128). Working with individuals should be characterised by empathy, respect and attention to the person’s dignity (115), paying due regard also to their history (102, 103, 109, 117).

SARs also focus on the lack of (robust and holistic) risk assessments (101, 102, 105, 106, 112, 116, 121, 125, 130, 132), including fire risk with smokers from the use of emollient creams (131)
and suicidal ideation (109). Risks should be considered individually and collectively, culminating with thorough management plans (106, 127). SARs also emphasise the importance of a multi-agency approach that includes discussion of how self-neglect is viewed and routine updating in order to integrate responses to relapse indicators or welfare concerns (106, 111, 114, 117, 122, 129). Assessments should also be evidence based, drawing on all available information rather than relying solely on a person’s self-report (103, 122, 124, 129). Risks to other people should not be underestimated (120). Assessments should be broadly rather than narrowly configured, not just concentrating on presenting problems or on what is visible and practical (125, 134). All legal options should be considered to support risk management plans (104). SARs focus too on missed opportunities to conduct mental health assessments (102, 109, 110, 121, 128, 130). Referrers must be clear whether they are requesting a mental health or a Mental Health Act assessment (110, 133, 134).

The subsequent planning should build on completed assessments. However, care plans do not always meet professional standards in terms of specificity and outcome-orientation (114, 116, 125), nor are they always followed through (121). Other agencies may not be consulted (109, 113, 121, 122). The multi-agency planning is especially important at points of transition, with information sharing, time, flexible working and use of specialist expertise all possibly indicated (109, 111, 118, 123).

Nonetheless, SARs also report good practice, such as evidence of making safeguarding personal (112, 123, 128, 131) and positive engagement that demonstrated consistent support, compassion and concern (104, 108, 111, 113, 114, 117, 118, 121, 125). Quality reviews are noted of mental capacity assessments, risk assessments and care plans (101, 115, 123).

**Domain B: the professional team around the adult**

Across health and social care, housing and uniform services, there are examples of good practice – raising safeguarding concerns, information sharing, diligence and persistence in engaging with individuals, thorough discharge planning and follow-up, and working together (101, 104, 108, 109, 114, 115, 117, 118, 120, 125, 129, 130, 131, 134).

However, familiar criticisms continue of silo working, rigid eligibility thresholds and inflexible agency responses, which negatively impact on the support offered and leave people in harm’s way (102, 106, 120, 121, 128). People are referred on, or back and forth, with individuals with dual diagnosis particularly vulnerable to revolving agency doors (102, 128) rather than perspectives shared to inform integrated risk assessments and management plans. Awareness is lacking of what different agencies are already offering in a case or can contribute to safeguarding (108, 117, 123, 126, 128, 131), with assessments completed in isolation (111, 116) and adopting a narrow focus (131).

Approaches are uncoordinated and disjointed (110, 111, 114, 121, 132, 133), with services failing to communicate, deliver timely provision and/or clarify their respective roles and responsibilities (105, 108, 109, 112, 116). The absence of strategy meetings meant that there was no overall analysis of known information and no shared, agreed approach to assessment, case management and contingency planning (112, 116, 125, 127, 131, 133, 134). Hospital discharge is a pivotal moment when multi-agency coordination is essential, including information sharing, risk and mental capacity assessments, accurately identifying the community GP, notifying agencies involved and recommencing community health and social care services (107, 109, 112, 113, 121, 125, 128, 129, 130, 133).

A clear message emerges of the importance of multi-agency meetings, to support reflection and shared decision making (104), with one agency or practitioner having a lead co-ordinating role to develop and oversee case management planning (102, 105, 106, 107, 108, 115, 120, 122, 124, 125, 130). Multi-agency meetings are highlighted as particularly beneficial when a case has yet to reach the safeguarding threshold but where there are concerns about how agencies are working together to understand and manage risks (120, 128).

Even when held, multi-agency meetings would benefit from being more structured to improve coordination, continuity and communication between services (101, 126), for example,
when transferring cases between individuals or teams and when individuals are moving between settings, such as hospitals and home, and need services to restart (108, 113, 122). When key professionals and agencies are absent from meetings, arrangements must be made to ensure that they contribute to the on-going plans (110, 117).

Effective working together depends on information sharing between community and secondary healthcare settings, district nurses and GPs, children’s and adult social care, police and mental health providers. However, this was frequently found to be poor, resulting in no shared understanding of risks, for example, arising from non-engagement or mental distress, or agreed multi-agency approach, and culminating in missed assessment opportunities and disjointed or delayed service provision (103, 107, 108, 111, 112, 116, 117, 120, 121, 122, 125, 127, 129, 130, 132, 134). Three reviews (102, 110, 134) also highlight the importance of communication and a multi-agency approach when individuals are placed across county boundaries.

Three reviews highlight the risks to the multi-agency case management when a hierarchy of professional or agency voices exist (111, 128, 131). When practitioners with particular knowledge of the case are not invited to meetings, or their concerns minimised, opportunities for information sharing and joint risk assessment and care planning are lost.

Legal literacy is highlighted (114, 132) with staff requiring a better understanding of all legal options. The variable knowledge of mental capacity and mental health legislation is specifically highlighted (110, 111, 133). Other reviews concluded that there were failures to seek a legal advice (133), to appreciate when the right to private and family life can be qualified in order to share information (116, 128), to undertake care and support assessments (Care Act 2014, section 9) (115, 130) and to obtain injunctions to protect a person from abuse (114, 127). In case 129 the individual was not seen despite statutory obligations on agencies to remain in contact. In case 104 local authority funding was not explored when the individual refused to pay for services.

Safeguarding literacy emerges (102, 111, 114, 116, 121, 123, 127, 128, 130, 133, 134) through concerns about the poor management and investigation of alerts, the failure to follow approved procedures, delays in raising or following up concerns and poor communication about levels of risk. Sometimes adult at risk management procedures were poorly understood (120); sometimes safeguarding referrals were simply passed on to an agency known to be involved (111, 114); sometimes thresholds were misunderstood and/or misapplied or referral information was not triangulated with other available information before decision making on whether to proceed with a safeguarding enquiry (106, 107, 108, 114, 116, 125, 127). Occasionally, children’s services staff and police officers were criticised for not understanding adult safeguarding law and procedures (103, 117).

One feature of safeguarding specifically highlighted is escalation, with available procedures not used (108, 114, 123), or unclear and ineffective (105, 118, 126, 127). Sometimes concerns were not escalated (107, 116, 120, 122, 125, 131). Effective safeguarding depends on agencies challenging each other’s decisions when concerns remain in order that alternative options are explored.

Some reviews are critical of recording standards (101, 106, 108, 114, 115, 116, 117, 121, 122, 129, 131, 132), for example, of mental capacity and risk assessments, safeguarding concerns, medication and appointment management, referrals, care plans and decision-making rationale. Sometimes the criticism was of dispersed records or out of date information (107, 112) and of delay in transferring information, for example between GPs, with the result that newly involved practitioners were unsighted on case history and concerns (110, 111, 123). Sometimes criticism is directed at IT systems that construct barriers to information sharing and/or do not flag risks (116, 117, 125).

**Domain C: organisations around the professional team**

One theme is commissioning for complex cases (109, 111, 113, 114, 120, 128, 129), both residential and community, often involving mental health, addictions and/or non-compliant or chaotic behaviour. One review (115) explores the interface between commissioners and providers; another (108) observes that care home providers were not seen as part of the wider
system responsible for ensuring personalised care. One review (117), in a context of market gaps, criticises domiciliary care agencies for taking contracts without the necessary capacity to deliver the requirements.

Glimpses are afforded into practitioners’ working contexts. Cases (103, 114, 120, 130, 131) refer to the impact of organisational change, others (103, 110, 114, 116, 117, 123, 131) to the impact of staffing issues – vacancies, workloads, availability of advocates or specialist practitioners. Five cases refer to the impact of austerity on availability of care packages, care pathways and/or placements or services to address complex and challenging needs (105, 114, 117, 129, 132).

Supervision, training, and senior management oversight remain constant themes (104, 105, 107, 111, 116, 117, 120, 121, 125, 127, 128, 129, 130, 133, 134). Poor practice is not corrected, risks are not discussed, practitioners have insufficient knowledge and/or skills for the complexities that they encounter, including cultural awareness and identification of mental distress, and understanding of safeguarding procedures is lacking. Robust review and oversight are sometimes absent, with patchy performance monitoring and inadequate responses when staff raise concerns about feeling anxious or powerless in relation to risks of foreseeable harm. Support should be offered to enable staff to manage complex cases (114), including the availability of mental health, mental capacity and law specialists so that all options are considered. Staff must be able to put knowledge and skills acquired in training into practice, reiterating the importance of workplace as well as workforce development (Braye et al., 2013).

Evidence continues to suggest that available procedures are not used, for instance for convening multi-agency meetings regarding adults at risk of harm (102, 103, 116, 131). One review (127) suggests that in a particular working environment there were too many policies for police officers to read and know. Yet faith in procedures remains prominent, with SARs (103, 111, 116, 130) recommending policies for self-neglect, missing persons, suicide risk and escalation. Unusually, given that reviews often eschew comment on the wider legal and policy system beneath which sit local adult safeguarding arrangements (Preston-Shoot, 2016), three SARs critique national guidance – regarding non-disclosure of convictions of “informal carers” to an adult at risk (101), non-notification of an individual’s move to another local authority area when a safeguarding alert has not been concluded (102) and lack of clarity about when self-neglect falls within Section 42 (Care Act 2014) and safeguarding, particularly when people with capacity display very challenging risk-taking behaviour (128).

Nonetheless, there are references to good practice, for example, supporting staff through grief and loss (128), diligent searches for specialist placements (114) and flexible commissioning to achieve person-centred outcomes despite financial pressures (131).

**Domain D: SABs and inter-agency governance**

Once again, in this sample this domain features less prominently. However, in line with statutory guidance (Department of Health, 2017) reviews comment on family involvement, frequently referring to the value this has added to the process, for example, when setting terms of reference or understanding key events in a chronology. What might facilitate such involvement is left unexplored. Otherwise, in terms of the process of conducting SARs, there are references to delays owing to parallel processes[1], finding independent reviewers (133) and obtaining quality contributions from some agencies (134). Other reviews observe that time constraints can limit the depth of investigation (113, 115), that inconsistent panel membership impacts on developing understanding of the review process (103), and that the passage of time between case events and the review itself results in loss of records and/or availability of staff involved at the time (132) and elevates the risk of hindsight bias.

More positively, some reviews mention participants’ candour, their willingness to engage in reflection, and effective management of the review process itself, including the availability of staff with specialist knowledge to act as advisors (103, 111, 114, 115, 122).

Emphasis continues to be placed on the use of SARs, so that lessons may be learned, but limited use is made of other reviews completed by the commissioning SAB and/or nationally[2]. Case 120 represents an interesting development, however, where the SAB determined that a
proportionate response would be to research learning available locally and nationally from other SARs, with links made across to the referred case. This SAB’s judgement was that this would be more likely to produce new learning.

SARs also pay attention to single agency action plans (for example 117, 118, 122, 123, 125, 134) and occasionally point to changes that have already been implemented. What is impossible to determine from the SARs, of course, is the lasting impact on system-wide change.

Demonstrating change

The analysis of SARs on self-neglect prompts two immediate observations. First, the significant learning can emerge when individual cases are reviewed, as captured in findings and recommendations. Second, thematic overviews across a sample produce a comparative and more nuanced perspective of the complexities involved in working with adults who self-neglect. However, a third observation also arises, namely that completion of an SAR opens another chapter, namely the transfer of learning into policy and practice, locally and beyond.

There has been little evaluative enquiry about whether learning from SARs directly impacts on policy and practice and little theorising about how to manage this challenge of effecting change within and across adult safeguarding systems. Stanley and Manthorpe (2004), surveying different kinds of enquiry, found mixed evidence of their effectiveness in changing systems and practices. Along with others who have conducted thematic analysis of reviews (Brandon et al., 2005) they questioned whether there was sufficient energy left after report publication for translating its recommendations into action for change.

The critique partly revolves around failure to disseminate and learn lessons locally, and to transfer them into wider policy and practice (Fyson et al., 2004; Cambridge, 2004; Devaney et al., 2011). Another aspect emphasises the difficulty of translating case-based findings to learning across practice (King, 2003; Horwath and Tidbury, 2009). Thematic reviews of SCRs have concluded that a stronger emphasis is required on creating robust learning cultures through which learning can be translated into action (OFSTED, 2008; Rose and Barnes, 2008; Devaney et al., 2011). One study of barriers and enablers to learning from reviews (Rawlings et al., 2014), at the practitioner level, focusses on workloads, support to manage the emotional aspects of casework, training and supervision to develop knowledge and skills and staff involvement in generating the learning to be implemented. At a service level, the study focusses on acknowledging that change takes time and sustained leadership, making reports and the learning from them accessible and relevant and creating a learning culture within and across agencies, with a continued programme to reinforce desired changes. It acknowledges that too many recommendations and changes can prove unsettling and create confusion in people’s roles and responsibilities. It advises the use of audits to monitor the impact of change.

Although its conclusions have been contested (Preston-Shoot, 2017b), the challenge of change was crystallised by the review of Wood (2016), which argued that SCRs had produced little effective change as evidenced by their repetitive findings. SABs must be able to answer the question of how they know that SARs have beneficially impacted on procedures and practice, at least locally. Thematic reviews have uncovered some positive findings regarding impact. Bray and Preston-Shoot (2017) found that review findings had already been used in service development. Action plans too were very specific, with an emphasis on subsequent audit and quality assurance. Preston-Shoot (2017a) also found that reviews had an immediate impact on service development within individual agencies and/or across the multi-agency safeguarding partnership. Recommendations and action plans were generally focused, the latter updated with progress made. Some SABs had developed focussed approaches to dissemination, involving briefings, the development of training materials, and conference presentations. Less prominent, however, were audits to explore the degree to which direct practice with adults at risk, and the supporting organisational and multi-agency context, reflected the desired changes.

Central government’s own experience of implementing recommendations from a review is illuminating and instructive. The Department of Health’s report (2015) on progress in transforming care following the Winterbourne View SCR (Flynn, 2012) admits that change has taken longer
than planned. Even with a step-change in leadership, achieving legislative and regulatory change has proved easier than addressing a fragmented commissioning landscape, the breadth and depth of provision required for people with complex needs, complicated funding systems and the availability of sufficiently skilled staff to ensure that service users receive the right support.

So, how might change be approached and achieved? The question to be answered (Rose and Barnes, 2008) is "how to create sustainable change?"

### Approaching change

In conceptualising an approach to implementing an SAR recommendations, components have been drawn from research on leading change (Kotter, 1995) and on utilisation of research (Walter et al., 2004), besides reflections on the review process itself (e.g. Fish et al., 2009; Horwath and Tidbury, 2009; Devaney et al., 2011). Although presented sequentially for clarity, the framework for approaching change is not so much a step-by-step model as a set of interlocking elements, all of which should always be kept in mind (Figure 1).

Participating in SARs impacts on staff involved and on relationships within and between agencies (King, 2003; Horwath and Tidbury, 2009). Some debriefing with practitioners and managers may be necessary and some rebuilding of collaborative arrangements to lay the groundwork for the desired changes. Momentum, what Kotter (1995) describes as a sense of urgency, is necessary to generate co-operation that ensures that the SAR will have an impact on policy and practice. Leadership is necessary here and throughout, with the board providing a powerful guiding presence (Kotter, 1995). The board’s acceptance of the SAR’s analysis and its implications is obviously important but the SAB also needs to have sufficient senior management engagement to drive the change process, supported by middle and practice managers, staff development personnel, commissioners and regulatory bodies (Walter et al., 2004). A review, therefore, of aspects of its governance may be necessary.

Action plans should be specific about what needs to change and how that outcome would be identified (Rose and Barnes, 2008). However, the action planning can become formulaic without articulating a vision (Kotter, 1995) for what good policy and practice looks like, as when working with cases of self-neglect. As Cambridge (2004) concluded, the desired state should be mapped, followed by the individual and organisational responses required to achieve it. SAR authors can assist here by building up a model for effective practice, here on self-neglect, by collating learning.

![Figure 1 Reflective questions on process and outcomes](image-url)
from individual and thematic reviews. Terms of reference for individual SARs, and quality standards for reviews (SCIE and NSPCC, 2016; London ADASS, 2017), should, therefore, include the degree to which already available learning is applied to the case in question and the recommendations emerging from it.

This is one point where a sustained relationship with SAR authors may be advantageous, assisting the SAB to develop and then implement its action plan (Figure 2).

Dissemination is one challenge. Simply publishing and/or circulating the whole report, or an executive summary, is too passive. To promote adaptation to change, the vision of what good looks like and its necessary component parts needs to be communicated to diverse management and practitioner audiences. Materials for doing so should be tailored explicitly for specific audiences. They include briefings and training materials, accessible and actively disseminated, with the implications for different staff and agencies clearly articulated (Walter et al., 2004). Expectations should be clearly stated about how they will be used actively by the teams to which they are sent, together with feedback sheets that team members complete to indicate how and when they have been understood and used.

Implementation is another challenge. It requires a whole system approach. It is not just a case of devising a new procedure or advocating a different orientation to practice. SARs take place “somewhere” and, whether or not all features of that place are acknowledged in the review, implementation of change as reflected in the recommendations will need to take account of the national and local social, political, economic, legal, regulatory and professional contexts.

Favourable political, organisational, inter-agency and staffing conditions must be created for change to occur; otherwise familiar barriers of staff turnover, resource constraint and workloads will frustrate the vision that underpins new procedures and/or desired practices (Cambridge, 2004; Rose and Barnes, 2008; Fish et al., 2009). A supportive political policy climate can ease adoption of new procedures and practices, recognising that some recommendations will require national action. Organisational structures and institutional cultures may have to be changed to allow desired practice to flourish – an alignment between workplace cultures and policies, agency procedures and practice (Walter et al., 2004; Braye et al., 2013; Pike and Wilkinson, 2013). Staff themselves should feel that they have the authority, as well as the training and resources, to deliver the vision being articulated in the review recommendations and subsequent action plan. Obstacles to change have to be identified and removed, what Kotter (1995) describes as enabling actions, with staff empowered to act in line with the articulated vision of best practice.

Figure 2 Reflective questions – taking learning forward

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<th>Dissemination</th>
<th>Implementation</th>
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<td>To whom are key messages being sent and how?</td>
<td>Are board partners active in leading the change?</td>
</tr>
<tr>
<td>What is expected from them?</td>
<td>Are staff empowered to implement changes in practice?</td>
</tr>
<tr>
<td>How will this be followed up?</td>
<td>Are agency structures blocking or facilitating change?</td>
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In working with adults who self-neglect, for example, that means staff being encouraged to build and maintain relationships, to provide continuity of concern and care.

No one service can deliver effective adult safeguarding alone so attention may be necessary on the health of inter-agency strategic and operational relationships. Working conditions experienced by staff can support adoption of change or create an unsafe environment. The focus here falls on what people bring to their work and the context in which they practise – their knowledge and skill mix, the optimism or pessimism with which they approach change, and their resilience and capacity for reflection, manageable workloads, supervision and the availability of spaces for reflection (Figure 3).

Once again, the board needs to be providing leadership, the powerful guiding presence (Kotter, 1995). Here, however, the focus is on using supervision, case audits and seminars to maintain a focus on embedding implementation (Walter et al., 2004) – to reflect back on what has changed (Rose and Barnes, 2008) and to assess current single and multi-agency strengths and vulnerabilities when working with the type of case in question when compared with what good looks like as identified by SARs and other research. One example (Rochdale SAB, 2017) is a multi-agency case file audit on self-neglect that lists known elements of good practice and then captures the issues uncovered, messages for practitioners and multi-agency recommendations.

It is tempting to conclude that the action plan has been completed when policies have been developed or revised, training offered and assurances received about practice and supervision. Closing down the action plan at that point, however, neglects consolidation and reinforcement of change. This is another juncture at which involvement of SAR authors might prove helpful in facilitating reflection on the journey travelled and the work still to be done to embed change.

Conclusion

The statutory guidance (Department of Health (2017)) advises that SABs may commission reviews of cases where work has been effective in preventing abuse and neglect or protecting adults from significant harm. Learning will emerge from reviews where practice has been effective, acting as a counterpoint to the messages from SARs. Statistics demonstrate that adult safeguarding is effective (NHS Digital, 2016) but the degree to which SABs are reviewing, auditing and disseminating successful practice is unclear.
Thematic reviews unify learning that otherwise remains localised and disparate. They, therefore, contribute to developing patterns of understanding and knowledge through the syntheses and generalisations, contrasts and comparisons that can be drawn. They provide one means of enabling SABs, individually and collectively, to scale up the impact of completed SARs.

Translating findings and recommendations into policy and practice is not straightforward. The argument in the second half of this paper is that SABs should act not just on the recommendations but on the different levels of context where change may be necessary to realise the ambitions reflected in the SAR’s conclusions. A longitudinal approach is needed to embed and then demonstrate the ultimate value of SARs, one that reaches beyond the completion of an immediate action plan to on-going evidence of practice and organisational change. It requires leadership and conversations that attend to cultures, structures, processes, feelings and relationships, to understanding the meanings given to what is happening and why, and then to acting into those human and non-human contexts to achieve change.

Notes
1. Examples include police investigations and criminal proceedings, inquests and inquiries by regulatory or professional bodies (122, 127, 132, 133).
2. Cases 120 and 134 by contrast do make use of other completed reviews.

References
Flynn, M. (2012), Winterbourne View Hospital: A Serious Case Review, South Gloucestershire Safeguarding Adults Board, Bristol.


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Reporting sexual violence on mental health wards

Marian Foley and Ian Cummins

Abstract
Purpose – The purpose of this paper is to report the findings of a scoping study that explored the extent of recorded sexual violence perpetrated on inpatients on mental health (MH) units.
Design/methodology/approach – A Freedom of Information Act (FOI) request was sent to 45 police forces. The FOI asked for the number of recorded offences of rape and sexual assault by penetration for the five years 2010–2015. Following the responses from the police, a similar FOI request was sent to MH trusts.
Findings – There were significant variations in the way that both police forces and MH trusts approached the recording of this information.
Research limitations/implications – The research highlights variation and inadequacy of current recording practices in relation to sexual offences committed against inpatients on MH units.
Practical implications – There needs to be more consistent systems of recording of allegations of sexual assault and responses to them by agencies. In the trust recording of these incidents, it is recommended that a specific category of sexual violence is created. On a national level, the Office for National Statistics should produce a national data set that records the number of rapes that are committed in MH inpatient units.
Originality/value – This paper highlights the “gap” of information in relation to recorded rape and may indicate that complainants with a history of mental illness are less likely to have their allegation recorded as a crime.
Keywords Mental health, Patient safety, Safeguarding, Sexual violence, Freedom of information, Trauma-informed approaches
Paper type Research paper

Introduction
This paper examines the reporting of incidents of rape and sexual assault on mental health (MH) inpatient units. Stenhouse (2013) uses the term “sanctuary harm” to capture the potentially damaging impact of abuse or violence that occurs to patients who have been admitted to a MH unit. Jones et al. (2010) see wards as both safe and unsafe places. It should be noted that the people with MH problems are much more likely to be victims of crime and abuse than the general population. Therefore, the MH unit might be a safer place, particularly if individuals have good relationships with staff and are familiar with the environment and other patients. The work of Jones et al. (2010) indicates that factors such as unfamiliarity with the staff group and witnessing the use of restraint and seclusion were factors that increased anxiety amongst patients. In total, 61 per cent of female patients reported harassment or abuse during an admission to a mixed sex psychiatric ward.

Sexual violence and MH
People who are using MH services are more likely than other groups in the population to have experienced sexual violence. It is, therefore, vitally important that MH services develop systems that respond to these issues. This would include not only ensuring that all MH staff are aware of the potential impact of sexual violence. In addition, the staff need to have an awareness of the potential links between experience of sexual violence and the development of MH problems.
In their examination of the experiences of physical and sexual violence, Scott et al. (2015, p. 5) identified six groups within the population:

- Relatively little experience of violence or abuse – this is the majority of the population, roughly 75 per cent. However, within this group 14 per cent reported having been bullied at some point.
- Physical violence from a partner – this group made up 10 per cent of the population. Over 60 per cent of this group reported that they had been kicked, bitten or hit by a partner.
- Extensive physical violence from a partner – this group made up 2 per cent of the population. Over 80 per cent of this group had been threatened with death.
- Sexual violence as a child (not in adulthood) – this group made up 5 per cent of the population. In total, 66 per cent had been “touched sexually as a child”.
- Sexual violence as an adult (and sometimes also in childhood) – this group made up 3 per cent of the population. In total, 30 per cent had had “non-consensual intercourse in adulthood”.
- Extensive physical and sexual violence as an adult and child – this group made up 4 per cent of the population. As well as being subjected to physical violence, such as being hit, bitten and kicked by a partner, individuals in this group had suffered “very high levels of severe sexual violence”.

People who have been subjected to the physical and sexual violence are more likely than other groups to develop MH problems. These difficulties include common mental disorders, eating disorders, psychosis and post-traumatic stress disorder (Scott et al., 2015). For example, Scott et al. (2015) note that the people who have been violently assaulted or abused are fifteen times more likely to make an attempt to take their own life than the general population. Rates of self-harm are five times higher amongst this group. In total, 84 per cent of those in the group who had been subject to “extensive physical and sexual violence” were women. In total, 12 per cent of this group had been admitted to a specialist MH unit at some point. This review concludes that the long-term impact of violence in all its forms should be viewed as a public health issue. The impact of violence can be seen across both physical and MH. There are well-established links with other concerns including, alcohol and drug dependency, smoking, obesity and childhood development.

People with MH problems are at greater risk of victimisation than the general population. Bengsten-Tops and Ehliasson carried out a study involving 174 patients. In total, 67 per cent of this cohort had been victims in adulthood, 39 per cent had been threatened at some point, 51 per cent had been assaulted and 32 per cent had been victims of sexual assault. In total, 33 per cent of the cohort had been a victim in the previous 12 months – 15 per cent had been subjected to sexual violence in that period. Women reported greater exposure to violence than men. Khalifeh et al. (2015) note that the focus of research on violence and serious mental illness has been on debates around whether people with MH problems are more likely than other groups to commit such offences. This is clearly a very important area but it does divert attention from the experiences of people with MH problems as victims of serious violent crime. The authors note that the relationship between serious mental illness and experiencing violence is a complex one that is most likely to be bi-directional. Service-user histories of trauma are often not acknowledged by professionals (Howard et al., 2010) or where they are there is not an appropriate response (Nyame et al., 2013). Khalifeh et al. (2015) conclude that men and women who experience severe mental illness and are in contact with psychiatric services are two to eight times more likely to experience domestic violence or sexual assault. This study also concluded that these experiences of violence could be a potential trigger for suicidal ideation. In the report “At Risk yet Dismissed” (Pettitt et al., 2013), 9 per cent of victims reported crimes that had taken place in psychiatric settings. This study is based on a series of interviews with people with MH problems who had been victims of crime. These interviews reveal the impact of violence with participants reporting that they felt fear, shame and embarrassment in the aftermath. The negative impact on MH was also documented with participants reporting feelings of distress. In some cases, the MH of victims deteriorated and the crime triggered a relapse and subsequent admission to hospital. The issue of reporting was also examined in this study.
Participants reported that one of the factors in their decision not to report was a fear that they would not be believed. Those who decided to report the assault to the police indicated that support from friends, family and professionals was a factor alongside a previous positive experience with the police. In addition, the concern that the offences might escalate and the wish to protect others were all positive factors in this process. This study also highlighted the concerns that individuals had that would prevent the reporting incidents to the police. A previous negative experience with the police was a factor here. However, the overarching concern was that they would not be believed. The interviewees were extremely conscious that the fact that they had a MH problem might potentially be used as a basis for discrediting their account. It is highly regrettable that many thought that they might even be detained under the Mental Health Act 1983 if they reported a crime.

Patient safety

The potential impact of sexual violence is such that it must be a priority issue for MH services. There are two elements to this: the first is that those using MH services may have been subjected to sexual violence; the second is that inpatients may be at greater risk. All patients are owed a duty of care, this extends to ensuring personal safety whilst an inpatient. The Care Quality Commission (2014) report raised concerns over the widespread use of petty rules in psychiatric units, for example, banning the use of mobile phones and the internet. These have become key features of modern life and it could be argued – citizenship. They are also important ways of maintaining contact with friends and families. Goffman (1968) in his outline of the culture of the “total institution” highlighted the social and physical isolation that they created. The CQC report noted that in 13 per cent of cases no one actually knew why the rule had been introduced in the first place. There have been ongoing concerns about the physical environment of MH wards. Quirk and Lelliott (2001) found that patients were concerned about life on the wards – they reported concerns about the lack of meaningful activity. Alongside this, wards were described as dirty and the food was poor. In addition, patients reported that they were concerned by the availability and use of street drugs on the wards. Patients in this study reported that they were concerned for their physical safety. This is a hugely important issue. Risk to self – in one form or another – is the core reason for admission to hospital. The personal safety of patients has to be a priority issue for all those working in MH care. In the inpatient setting, if patients are concerned that they are not physically safety then this will almost certainly have an impact on their MH. In the context of this research, these factors can contribute to an environment where individuals feel more vulnerable.

Sweeney et al. (2016) note in their review of trauma-informed approaches (TIA) that MH systems can be sites of initial trauma or further trauma. Trauma can be as a result of a single event or a series of events. The definition is broad enough to include experiences of interpersonal violence, for example, sexual abuse and physical assault as well social trauma, such as inequality and marginalisation. Individuals may experience personal trauma whilst at the same time being caught up in community traumas. For example, individuals fleeing a war zone may be subjected to forms of interpersonal violence alongside the trauma of being a member of a persecuted group in society. These traumas can be compounded by the reaction of authorities or public services to the individuals and family. Retraumatisation occurs when a person experiences an event that triggers memories of a past traumatic event. The current event then triggers similarly emotional responses – fear, anxiety, and depersonalisation – to those of the original event. Bloom and Farragher (2010) argue that current MH systems with their inbuilt focus on coercion and control have the potential to retraumatisse survivors. This may occur via the use of physical restraint and seclusion. There are pressures – for example, to cooperate with the terms of a community treatment order or to take medication (Sweeney et al., 2016).

Bloom and Farragher (2010) argue that staff are required to work in “trauma-organised systems”. Social workers and MH professional enter these systems with the aim of relieving suffering rather than inflicting it. The long-term impact on staff is the development of therapeutic pessimism or a loss of a sense of why they entered the profession in the first place. This is superbly illustrated in Filer’s (2013) novel The Shock of the Fall where the staff are unable to communicate with a young patient, Matthew, so do not understand the extent of his mental distress. Paterson (2014)
argues that TIA is a systems approach that focusses on how the impact of trauma affects and has impact across the fields of neurological, biological, psychological and social development. Services need to be organised and delivered in ways that recognise that service users have potentially been exposed to various forms of trauma. Services need to be delivered in an ethical fashion with the safety of service users as a paramount concern for all staff. TIA MH services are, thus, strengths-based approaches. They seek to recognise that complex behaviours have a function in both helping survivors manage and respond to situational triggers. Spandler’s (1996) work on self-harm is an example of this approach. It puts forward an approach that rather than seeing self-harm as a behaviour that needs to be managed, views it as a behaviour that has intrinsic meaning for the individual. This leads to a fundamental shift in thinking. TIA is, thus, described as a move from “what is wrong with you” to “what happened to you” (Harris and Fallot, 2001).

The National Patient Safety Agency (NPSA) has a key role in the monitoring of incidents that put any patients at risk in any way. This applies across health service providers. In their guide Seven Steps to Patients Safety, the key factors to the creation of a culture of patient safety include the promotion of reporting, involving and communicating with patients and public and learning and sharing safety lessons. In addition, staff should report “near misses” or “no harm”. NPSA recognises that there is a need for a greater awareness of the potential vulnerability of those experiencing MH problems when they are inpatients. It is not the main focus of this paper but the NPSA note that this includes an acknowledgement that sexual disinhibition is a not uncommon symptom of serious mental illness. Therefore, MH professionals have to manage a number of different aspects of this problematic issue. However, it is vitally important to emphasise that the focus of interventions needs to be based on the potential victimisation of patients.

The NPSA guidance starts from the premise that patients’ concerns must always be taken seriously. As noted above, one of the biggest barriers to the reporting of such incidents is the belief that victims hold that they will not be taken seriously and that this is, in part, due to their MH problems. As well as emphasising that any allegations will be taken seriously and crimes investigated, the guidance highlights that patients should have access to appropriate sexual health advice and support services. The physical layout of the wards should also be considered. There have been moves to create single sex wards more generally within health services. This appears to be of particular importance in this area. The Department of Health issued guidance recommending single sex sleeping, toilet and bathing accommodation in 2000. In 2004/2005, 99 per cent of institutions had completed these changes. The NPSA also notes that units that are in areas of high demand should resist the pressure to admit patients of the opposite sex to single sex wards in times of acute bed shortages. The wider pressure on MH services makes this an increasingly common problem that MH service providers have to face. The Royal College of Psychiatrists (2011) has issued general guidance “Do the right thing: how to judge a good ward on establishing a safe, secure and therapeutic ward”. The RCP has produced a checklist of ten areas that includes: a proportionate and respectful approach to risk and safety and a physical environment that is fit for purpose. The guidance does not explicitly discuss sexual violence but emphasises the importance of ensuring the physical safety of patients. It also highlights that separate toilets and sleeping accommodation for men and women is an important standard and a government policy. In themselves, these will not prevent incidents of sexual violence. However, they are all important in creating a culture that recognises the potential increased vulnerability of inpatients, takes step to prevent incidents and provides appropriate support to those reporting any incidents of sexual violence.

The National Reporting and Learning System exists to collate all reports of incidents. There is a general under reporting of incidents. The categorisation of incidents includes patients’ accidents – for example, slips and falls, disruptive and aggressive behaviour, self-harm and absconding. In 2016, incidents categorised under these headings accounted for 84 per cent of all reports. It should be noted that there is not a specific category of sexual assault or violence – either as a victim or perpetrator. The NRSL carried out an analysis of a sample of 200 incidents of disruptive or aggressive behaviour. Five incidents in this sample concerned sexual safety. As a result, a further search of the whole data set of incidents of disruptive and aggressive behaviour was undertaken. There were 122 reported incidents where concerns were the result of sexual behaviour – 19 rapes, 20 cases of consensual sex, 13 cases of exposure, 18 cases of
sexual advances, 26 touching and 26 other. The report notes that there was significant variation amongst Trusts in how they approach and report these incidents. When an incident is reported, the organisation has to assess the degree of harm that the impact has had on the patient. In 114 of these cases, “no harm” was reported. This is a striking conclusion. The impact of such incidents has to include the potential traumatic impact – physical and psychological. These incidents may well be examples of revictimisation. In the cases of rape, 8 attacks were perpetrated by patients and 11 by staff. In addition, the 20 cases that are described as being consensual sex raise a number of important questions about the nature of consent in such circumstances. They also beg the question why and when consensual sex would be described as disruptive or aggressive.

Developing appropriate, timely and sensitive responses to sexual violence is a key task for MH professionals. Since 2003, it has been the DH policy that all adult users of MH services should be asked about their experiences of violence and abuse as part of MH assessments – this was styled routine enquiry (RE). By 2006, it was clear that RE was not standard practice across MH settings. Scott and McLeish carried out a case study analysis of Trusts where RE was implemented. They found that it was a policy that required champions and key support from managers who ensured that it was on team meeting agendas and so on to be successfully implemented. The main barrier to RE was staff resistance. Staff were concerned about the possible impact of asking such questions, not all were comfortable with discussing such issues. It was also felt that RE would only be justified if services were able to offer effective and better support to patients in these circumstances Survivors felt that their experiences of abuse were not seen as central or relevant to their MH. In fact, this group indicated that they would have welcomed questions about these issues. The interviews that survivors had often had had contact with a range of services who had missed opportunities to ask these questions. A culture of secrecy and shame is associated with abuse – a culture which abusers exploit – which makes victims vulnerable to revictimisation. MH professionals can help to tackle this culture by asking appropriate questions and as importantly following up with good services.

Methodology

The aim of this research was to investigate the extent of serious sexual violence on MH units. The following Freedom of Information Act (FOI) request e-mail was sent to 45 police forces across the UK:

I am currently conducting a research study exploring serious sexual offences committed against individuals who were inpatients in psychiatric units at the time of the offence. Under the Freedom of Information Act 2000, I am writing to request anonymous information about recorded rape (Section 1 of the Sexual Offences Act 2003) and sexual assault by penetration (Section 2 of the Sexual Offences Act 2003) offences that have been reported and recorded by your constabulary between 1st January 2011 and 31st December 2015 involving a victim who was an inpatient in a psychiatric unit at the time of the offence – this group would include patients who were on section 17 leave from the hospital.

A data collection form was provided alongside the FOI request.

Following the responses from police forces, a similar FOI request was sent to MH Trusts in England. A decision was taken to request information from Trusts in England and Wales as no information had been provided by police forces in Scotland and Northern Ireland in response to an initial FOI enquiry. The incidents of sexual violence require responses from all agencies. These requests are part of a process of gaining a more detailed and or nuanced understanding of these complex issues (Table I).

<table>
<thead>
<tr>
<th>Table I</th>
<th>Police responses to FOI requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of FOI requests</td>
<td>45</td>
</tr>
<tr>
<td>Forces providing information</td>
<td>23</td>
</tr>
<tr>
<td>Forces unable to assist</td>
<td>22</td>
</tr>
</tbody>
</table>
The forces that were unable to provide information cited the amount of time and the cost of retrieving the data. Local MH unit addresses were not recorded in such a way as to make the information easily retrievable from databases. This would mean that each reported offence would have to be reviewed to check whether it took place on a MH unit. An organisation can refuse an FOI request if it will cost more than £450 to retrieve the data. This was the response from 22 forces. There was considerable variation in the data provided by the 23 forces that provided some data. This alongside the geographical and demographic differences in the areas covered by the forces makes meaningful comparisons impossible on the basis of the information provided. For example, ten forces provided on recorded s1 and s2 offences against inpatients. Even within this small sample, some forces gave aggregate data whilst others provided more detailed information such as the place where the reported offence took place.

As part of the FOI, forces were asked to complete an information sheet about the offences. These were often missing or incomplete. The information that the study was able to gather about the offences and the relationship between perpetrators and victims is provided in Table II.

When individual incident sheets were completed the information was incomplete. It was, therefore, difficult to reach strong conclusions about patterns of offending. However, the information provided indicated that women were at increased risk but both men and women reported assaults. From the limited information available from the police data, there were 20 female and 12 men victims. The information about the perpetrator was not always available. In cases where it was recorded, there were 26 males (two of the cases recoded involved two male perpetrators) and one female. The two most common groups of perpetrators were fellow patients (10) or nursing or staff members (10). The offences were recorded as taking place in the patient’s room (10), hospital grounds (7) or communal areas (6) (Table III).

As with the FOI requests to the police, there were signification variations in the reporting and collation of the data. A nil return by a MH Trust indicates that there were no such reported offences in the period covered by the FOI request. In total, 6 of the 12 Trusts that did not collect the data advised the authors to contact the police for the information. The MH Trust that turned down the FOI did so on the grounds that complying with it might breach patient confidentiality. In these cases, there were four female and four male victims. No further information was provided about the location of perpetrators or their relationship to the victim.

<table>
<thead>
<tr>
<th>Table II</th>
<th>Information from police FOIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victims</td>
<td>32</td>
</tr>
<tr>
<td>Female</td>
<td>20</td>
</tr>
<tr>
<td>Male</td>
<td>12</td>
</tr>
<tr>
<td>Perpetrators</td>
<td>27</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
</tr>
<tr>
<td>Male</td>
<td>26</td>
</tr>
<tr>
<td>Relationship to victim</td>
<td>10</td>
</tr>
<tr>
<td>Staff</td>
<td>10</td>
</tr>
<tr>
<td>Fellow patient</td>
<td>10</td>
</tr>
<tr>
<td>Place where the assault took place</td>
<td>10</td>
</tr>
<tr>
<td>Patient’s room</td>
<td>10</td>
</tr>
<tr>
<td>Hospital grounds</td>
<td>7</td>
</tr>
<tr>
<td>Communal area</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table III</th>
<th>Mental health trust responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of FOI requests</td>
<td>38</td>
</tr>
<tr>
<td>Trusts that provided a nil return</td>
<td>13</td>
</tr>
<tr>
<td>Trusts that provided some information</td>
<td>12</td>
</tr>
<tr>
<td>Trusts that did not collect the data requested</td>
<td>12</td>
</tr>
<tr>
<td>Trusts that turned down the FOI</td>
<td>1</td>
</tr>
</tbody>
</table>
Conclusion

The results of this research are consistent with the studies outlined in the introduction. Sexual assaults and rapes do occur in MH inpatient units. The recording of incidents of sexual violence by MH Trusts and police forces varies considerably. The Office for National Statistics confirmed (e-mail correspondence with the authors) that there is no national data set for sexual offences that are committed on MH inpatient units. These findings draw on small numbers and incomplete data but they highlight the variation and inadequacy of current recording practices in relation to sexual offences committed against inpatients. The data collected by MH Trusts obscures sexual violence as these incidents are recorded in a much generalised category of disruptive and aggressive behaviour. This system of recording also means that it is impossible to gain a clear picture of the extent and nature of this problem. Without this, comprehensive services to prevent sexual violence but also to support those subject to it whilst inpatients, cannot be developed. Ellison et al. (2015) argue that we know very little about the extent of victimisation, police responses or how a MH diagnosis or history influences notions of credibility for witnesses. These findings highlight a “gap” in the recording of information in relation to rape. It may indicate that complainants with a history of mental illness are less likely to have their allegation recorded as a crime (Ellison et al., 2015). The findings also suggest that there are the concerns about patient safety that are expressed in general policy, in practice there was considerable variation in how Trusts responded to our request for information and the data they had available to them. What is clear is that Trust responses to these allegations consider the role of the patient’s underlying condition both in relation to the allegation and the substance of that allegation. Some Trusts were willing and able to provide some overall statistical data but some made it clear these were allegations not convictions.

Existing research then would indicate that adult inpatients, especially women, are at increased risk of sexual victimisation and are less likely to have their allegations recorded as a crime. When they do they experience much higher rates of attrition than other rape cases (Ellison et al., 2015). Despite this background knowledge, the recording practices of both the police and NHS Trusts remain hugely variable and incomplete. It seems evident that for adults with MH histories/diagnosis, incidents of rape and sexual assaults, as with the adult population more generally, is underreported. From the scant information available, adults are likely to be at risk from fellow patients and members of staff and hospitals may contribute to, rather than diminish further victimisation. Given this situation, it seems imperative that we have more regular and accurate reporting of rape and sexual assault and that Trusts show a greater willingness to record allegations and collate more detailed information of the incident and their responses to it. We would recommend that police forces explore ways of recording MH unit specifically when dealing with such offences so the collation and analysis of data can be completed. We would also recommend that Trusts and the NPA record these incidents separately from others of disruptive or aggressive behaviour.

References


Further reading


Hester, M. (2013), From Report to Court: Rape Cases and the Criminal Justice System in the North East, University of Bristol in association with Northern Rock Foundation, Bristol.


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The sexual street harassment battle: perceptions of women in urban India

Jehangir Bharucha and Rita Khatri

Abstract

Purpose – In India, women feel unsafe particularly in public spaces and single women feel threatened in almost every context (Nag, 2016). The purpose of this paper is to examine women’s safety in the metropolitan city of Mumbai and argue that we need to address this issue and respond to the dearth of firsthand knowledge about women’s safety in India which is investigated in light of the social and cultural milieu. The study makes several recommendations based on the research findings.

Design/methodology/approach – The data collection was done in three separate stages. In the first phase, a structured questionnaire was administered orally to around 300 working women all over the city of Mumbai and its suburbs. The second stage adopted an exploratory qualitative approach using in-depth interviews and reflections. In the third stage, the authors audited busy areas on various parameters that might hamper women’s safety.

Findings – All the raw data obtained were analyzed using qualitative data coding and categorized to generate themes. Six clear themes emerged which include: perception of safety; safety in transportation; actual violation of personal or physical safety; negligible reaction by the victims; experience with the police; and firsthand recommendations and strategies. This study brings to light the disturbing fact that 91 percent of women worry about their safety all the time or most of the time when they are outside their homes. On the streets of the city almost all had experienced some tangible threats to their safety at some point of time.

Originality/value – Hypocrisy in the treatment of women is precisely what makes India unsafe for women. Although Mumbai ranks as the safest city in India, the study portrays that it is unsafe and fearsome for women. The recent much publicized crimes against women especially rape cases have made women’s safety an important topic for research. Not much primary research exists in this area.

Keywords Safety, Crime, Women, Harassment, Fear, Rape, Eve teasing

Paper type Viewpoint

Introduction

India is a land of rich ancient culture and tradition. In the Indian tradition, women are worshipped as the goddess of the family (Spina, 2016), yet they continue to be subservient to men. Traditionally, Indian women had been homemakers. The notion that India’s patriarchal society thinks of women only as homemakers and sexual objects and generally subject to exploitation and torture (Dube, 2001) is now changing as proper education and the ever increasing cost of living has made them move out of their houses and choose careers. Although women are excelling in all fields and striving to be at par with men (Bharucha, 2016), it is still believed in the rigid Indian society that the man is the primary bread winner of his family and women have only a supportive role to play. According to Human Development Report (UNDP, 2016), India is still ranked 131th in the world in gender equality. It is a fact that women have to face problems just by virtue of them being women (Kumari, 2014). Women particularly feel unsafe in public spaces and single women feel threatened in almost every context (Nag, 2016). Crime against women is increasing every year and has doubled over the past ten years (Nigam, 2017). As per a report by the National Crime Records Bureau (2015), on an average 26 crimes per hour against women are reported, at least a complaint every two minutes. These figures are probably underestimations as many incidents probably go unreported due to fear of stigma and non-awareness of rights.
Casual conversations with women in Mumbai revealed that even today women do not feel safe at home, outside the home or at the workplace. The most common complaint among women was eve teasing (which is the common euphemism in South Asia for sexual harassment of women in public areas by men). There are also countless cases of indecent gazes, pinching and comments that infringe upon the right of women, especially in overcrowded spaces and while using public transport (Nagindrappa and Radhika, 2013). According to Ahmedabad Women’s Action Group (2017), there is a big list of crimes committed on women in India such as acid attacks, child marriages, domestic violence, forceful domestic work, child abuse, dowry deaths, female infanticide, sex-selective abortions, child labor, honor killings, rape, sexual harassment, trafficking, prostitution and many more. Most of the crimes registered with the police pertain to rape, acid attacks, dowry deaths, sexual harassment, kidnappings and human trafficking (Farouk, 2015).

A study by Dhillon and Bakaya (2014) looking at street harassment in Delhi found that street harassment was so prevalent that every woman felt the fear of harassment. A study conducted in Kashmir on eve teasing as a form of violence by Akhtar (2013) found that 100 percent of the women had experienced eve teasing and that it happened in all places, with only 1 percent of the incidents being reported. Prasad (2016) studying crime on women in the two Indian cities of Delhi and Mumbai found that physical assault was the second most common crime in Mumbai while in Delhi it was sexual harassment. Both the crimes of assault and sexual harassment occur mostly in open areas or on the streets. Dalal and Lindqvist (2012) using the Indian National Family Health Survey data of 1,24,385 married women from all the 29 states of India recorded experiences of emotional violence (14 percent), less severe physical violence (31 percent), severe physical violence (10 percent) and sexual violence (8 percent). They concluded that women of the scheduled castes (the most disadvantaged socio-economic groups in India) and women from Muslim families were most often the subjects of domestic violence.

Elizabeth Stanko (1993) examining women’s fear of crime in certain parts of the USA found that women’s anxiety about danger is largely a fear of men and reflects women’s position in a gendered world. Yavuz and Welch (2010) using data from the Chicago Transit Authority Customer Satisfaction Survey identified the most dominant factors that make women fear crime in public space and inferred that safety-related problems affect women significantly more than men. Also, the presence of video cameras does not have a great effect on women’s feelings of safety. Day (2010) investigating women’s fear in public spaces in Irvine, California, also concluded that fear in public spaces negatively impacts women’s lives and even when danger is low, the idea of women as endangered in public space endures. Braungart et al. (2012) investigating the factors responsible for the fear of crime among women found that fear of being victimized is especially prevalent among the most isolated and vulnerable sections of women. A study conducted by Osmond (2013) in Coventry, UK, found that 61 percent of the women surveyed had faced sexual harassment at least once in the previous year with the harassment having profound emotional toll and necessitating alteration of behavior in public spaces.

The recent much publicized crimes against women especially rape cases have made women’s safety an important topic for research. Not much primary research exists concerning street harassment of working women in India. This paper examines women’s safety in the metropolitan city of Mumbai and argues that we need to address this issue and respond to the dearth of firsthand knowledge about women’s safety in India. It investigates the extent of retaliation by these women and the extent of intervention by the police when such cases are reported. This asserts the importance of a firsthand perspective in investigating the relationship between women’s safety and the social and cultural milieu. Several recommendations based on the research findings have also been included.

**Research design**

**Setting**

The current study investigates the issue of working women’s safety in India to understand firsthand the nature of sexual harassment and the ways in which we can address it. The data were collected in the metropolitan city of Mumbai.
Sample size
The respondents in this study included around 300 working women walking through busy markets and railway stations all over the city of Mumbai and its suburbs, out of which the views of 227 working women have been used for the purpose of this study. The age of the women chosen was kept between 18 years to 38 years so as to get better understanding of the sexual harassment faced by this particular section of women.

Data collection
The data collection was done in three stages. In the first phase which started in the month of January 2017, a structured questionnaire was administered to around 300 working women. The second stage adopted an exploratory qualitative approach using in-depth interviews and reflections. Out of the respondents, 80 were randomly selected and contacted at a later stage during the months of April and May 2017. Face-to-face interviews were conducted with these women, with some replacements from the list. The interview process was based on an interview protocol which addressed the research questions and provided the structure. The interview guide was divided into eight sections from which the six final themes ultimately emerged and this was done between March and June 2017. In the third stage, the authors audited eight busy areas in Mumbai city and suburbs on various parameters that might hamper women’s safety. Both the authors with three trained investigators visited these busy areas. The walking areas were mapped. The areas selected were busy streets and transport terminals. Careful attention was paid to areas having less lighting on the streets after dusk. The audit consisted of field survey and conversations with around 50 women pertaining to their difficulties in order to get firsthand understanding of their sentiments. Care was taken to interview working women only. The survey was carried out on three days during morning peak hours between 8.00 a.m. and 10.30 a.m. and evening peak hours between 5.30 p.m. and 7.30 p.m.

Data analysis
Quantitative data analysis was carried out for the first stage. For the qualitative analysis, all the raw data obtained through interviews as well as the observations were analyzed using coding and categorized to generate themes.

Findings and inferences
Six clear themes emerged from the responses collected via the structured questionnaire, the audit and particularly from the in-depth interviews. These include: perception of safety, safety in transportation, actual violation of personal or physical safety, negligible retaliation by the victims, experience with the police and firsthand recommendations and strategies. Quotations used in each theme shows word-for-word annotations by the respondents. Respondents are referred to by a number.

Perception of safety
This study brings to light the disturbing fact that 91 percent of women worry about their safety all the time or most of the time when they are outside their homes.

As seen in Figure 1, 5 percent (11) of the respondents found the city very safe, 26 percent (61) moderately safe, 25 percent (57) somewhat safe and 44 percent (98) unsafe. When the women were asked to comment on the degree of their safety in Mumbai city, the phrase “depends on the area” inevitably came up. This is indicative of the varying levels of safety in different areas. Out of the several factors that affect women’s perception of safety in an area, good lighting (68 percent), patrolling by police (52 percent) and the presence of shops and establishments (29 percent) seem to be the most dominant factors. Certain areas however have a higher crime rate than others, and women are wary of visiting such areas unaccompanied after sunset. The ingrained concern about their safety is evident in comments such as these:

After the gang rape of a popular actress by her former employees in a car in broad daylight, fresh doubts come on our mind about our safety (72).
We are living in a country and culture sickeningly unsafe for women (41).

Whither safety in a country where well known politicians issue statements “Boys will be boys, they do make mistakes”? (187).

On a scale of 1-10, the overall perceived safety at railway stations was 6.83 out of 10. A majority of women pointed out that deployment of constables and in particular women constables at and around busy railway stations is woefully inadequate. While most of the areas inside the station and at the ticket counters are fairly well lit, the station exits, the areas below the bridges, the areas around the toilets, certain corners of the station and the area outside the stations ranked very low in terms of perceived safety. Many women doubted whether the CCTV cameras at most stations were functional. The street markets were not seen as women-friendly either. The women confided that they rarely see constables patrolling these markets; instead, the constables have a tendency to gather in one spot and engage in animated conversation. The street markets had spaced street lights which were not adequate to provide lighting for all of the market areas. Several of the women pointed out that the vehicles parked around the circumference of the station made it easier for the males to leer at women and a lot of harassment occurs around these parking areas. Majority of women opined that despite living in India’s safest city, women tended to avoid certain things such as walking alone at night because they were fearful of crime and would definitely have wanted to feel safer. Thus, the mobility of women got restricted. This study shows that sexual harassment in public places is a deep-rooted problem that has become normalized in the society. Several street lights were obstructed by trees and some lights do not work which causes certain areas and lanes to become completely dark. Several areas have shops under the bridges where the light from the street lamps did not reach. The street lights were normally switched on around 6:45 p.m., whereas the daylight tended to fade away at least half an hour earlier.

This study highlights that 98 percent of women worry about their safety when they travel alone within India but not so much when they travel to international destinations.

Safety in transportation

As seen in Figure 2, the local trains seem to be the most favored mode of transport in Mumbai used by 34 percent (75) of the women, followed by public buses 25 percent (57), the metro 21 percent (48), taxi services 8 percent (19), private cars 8 percent (19) and other modes 4 percent (9). The majority of women in Mumbai use public transport for want of a better alternative but they admitted to feeling unsafe. Majority of them avoided using local buses at late hours and during the peak hours.

Also 44 out of the 227 women surveyed were provided company transportation which is always a safer alternative as opposed to the more widely utilized public transportation. These respondents

![Perception of safety](image)
were in high positions and were employed with multinational corporations. Majority of the women participating in this study worked during the daytime hours which increases significantly the safety involved in the use of public transport. Out of the 52 women who worked late hours and night shifts, the company provided adequate travel provision to 29 whereas the rest had to arrange for their own transportation.

**Actual violation of personal or physical safety**

Majority of the women 76 percent (173) affirmed the absence of any kind of physical or sexual harassment at the workplace. However, one quarter of the respondents (54) did report occurrence of some such incidents at the workplace. However, on the streets of the city almost all women had experienced some tangible threats to their safety at some point of time. A total of 77.2 percent (175) respondents had been subjected to lewd comments, cat-calls and insinuating songs by men. Close to 30 percent (68) of the total respondents had been stalked by a man at some point of time in their lives. A total of 29 percent (65) of the respondents had been groped or touched inappropriately, 7 percent (16) respondents had been molested at some point of time and 4 percent (9) women had also been subjected to other similar advances or felt violated in some or the other way. These responses are alarming and reflect violation of women’s rights on a large scale. Most of the women attributed all this to the patriarchal mindset of the Indian society: 77 percent (175); absence of fear of the law: 57 percent (131); and lack of effective police patrol on the streets: 45 percent (102). Some of the other opinions included indecent depiction of women in pop culture and movies: 33 percent (76); easy access to pornography: 22 percent (51); poor street lighting:13 percent (31) and women’s choice of apparel: 5 percent (11).

**Negligible retaliation by the victims**

It is clear that such incidents were very common and the victims had probably become immune to such incidents. There were several thoughts that went on in a woman’s head when confronted with such a situation. Out of the 52 percent (119) respondents who had retaliated some kind of action against such incidents, the majority had retaliated verbally whereas only 12 percent (28) had retaliated physically. A total of 4 percent (10) women had asked the people in the vicinity for help and only 2 percent (4) women had approached the police. However, despite the constant fear, only 13 percent (29) of the women carried an item for self-defense like a taser or pepper spray when traveling to a new unfamiliar place or city. Many of the respondents confided said that they had been witness to the harassment or teasing of other women and had rarely intervened.

**Experience with the police**

Only 24 respondents out of the 119 who had retaliated in some way against this harassment had reported the incident to the police out of which none were satisfied with the outcome.
The lax attitude of the police toward such incidents generally influenced the decision not to report. A huge percentage of women 71 percent (162) had no faith in the police and believe that the police cannot curb such incidents.

**Firsthand recommendations and strategies**

As seen in Figure 3 among the suggestions to combat this serious issue, harsh punishments against men to instill fear in their minds (62 percent) topped the list along with instilling the concept of gender equality from a young age (57 percent), fast-track courts (54 percent), better patrolling by the police (38 percent), sensitization of the police force (31 percent) and courses in self-defense (24 percent). Lighting on all streets and public areas needs to be functional and adequate. In an India where technology is now ubiquitous, emergency apps could be relied upon in case the women face any kind of danger. Several respondents in this study suggested increasing the number of women bus drivers and a “between stops” request on public buses, where women passengers could be dropped.

**Discussion and implications**

The study highlights the extent of sexual harassment in public places in Mumbai city. Although Mumbai ranks as the safest city in Mumbai, the study portrays it is unsafe and fearsome for women. The street harassment is so deeply ingrained that people may not even pay attention to it. This study shows that almost all women irrespective of their social status living in what is touted as India’s safest city irrespective of their socio-economic status have faced some kind of incident involving an infringement their personal and physical safety. Women who have suffered the humiliation and harassment show certain peculiar characteristics in their behavior such as being frightened, guilty, powerless, angry, ashamed, depressed, numb and lacking self-confidence (Kapoor and Dhingra, 2013). Women do feel unsafe out in the open especially outside the daylight hours and even in their own neighborhoods. Our results are in line with those of Mahedevia et al. who concluded that women are exposed to risk in Indian cities due to absence of reliable public transport services along with the lack of enabling infrastructure. This deprives them from accessing public spaces and the many opportunities these public spaces provide. A study by Borkar (2017) authenticates the view that women are willing to choose a college in the bottom half of the quality distribution over a college in the top quintile for the sake of a route that is perceived to be safer.

This study reports that the reason for this perception about absence of safety is the lack of gender-friendly environment, consumption of alcohol by males in the numerous bars on the streets, inadequate lighting, unclean public toilets, vehicles parked on both sides of the road,

![Figure 3 Suggestions to improve safety](image-url)
narrow sidewalks, lack of effective police support and lack of functional helpline numbers. The women in our sample attributed their harassment to the patriarchal structure of the Indian society, lack of police action, easy access to pornography and their own tolerant spirit. This study clearly reiterates that even modern Indian women subscribe to the all-encompassing cultural norm that women are more vulnerable than men and so they are more likely to be victimized. Thus it could be perceived vulnerability and not actual vulnerability that is a main contributory cause of this fear. Social scientists have differing views on the causes of women’s fear of crime. Some have argued that women’s heightened fear of crime is due to women’s higher levels of physical vulnerability compared to men (Smith and Torstensson, 1997) although feminist work generally resists this generalization and often tries to relocate the cause to larger societal factors (Skogan and Maxfield, 1981). Though almost all women interviewed wished to speak out against all acts of harassment, the panic of possible escalation is cited as the biggest deterrent. In any case, underreporting of these incidents is very common. They deal with this unnecessary attention by totally ignoring it rather than responding in any way to it. Even the parents of the victims fear that the family reputation would be at stake if they speak out. To top it all, the police generally have a lax attitude toward such incidents and avoid registering them.

The best solution would be that Indian families must “raise their boys right” and instill in them respect for women. The Indian culture teaches boys value in life but not in close relationships. Even though education and employment are today great empowering factors for women, in the Indian society women rarely get power on their own – it is only through men that they gain or lose power (Nigam, 2017).

This research shows that sexual harassment in public places is a deep-rooted problem that has become normalized in this busy city. It is as though the responsibility is on the women to continuously monitor their safety while men are free to prey. The mainstream response in India to any crime against women is to reduce their freedoms, choices and rights. Another point highlighted in this study is the almost total lack of action against the people who are guilty of all this. The almost zero incidences reporting of such crimes along with the lacksadaisical attitude of the police gives almost a green signal to those who commit such crimes. However, women who have been sexually harassed on a previous occasion start feeling unsafe all the time mentally and emotionally.

Women of the lower economic classes in India have a tradition for silence and would be unwilling to speak out. Among the upper classes even though education and employment are today great empowering factors for women, women may not talk about it in order to uphold the social status. There is an urgent need to fully understand this issue so that women feel safe as possible in their own country.

The perception of safety by women is greatly influenced by the design of public spaces in the cities where they live, and has an impact on any associated fear and consequently on their mobility. Bright lighting, presence of police and presence of several shops and establishments along streets would enhance their perception of safety. Spaces within and around schools and colleges have become hot beds of harassment. In fact, educational institutions should connect girls and women to key resources for seeking help in responding to such incidents. There is a need for an all-embracing public app for sexual harassment so that the whole process becomes simpler and women then find it easy to report such incidents. The police need to be adequately spaced out across public spaces and railway stations and there ought to be more women constables. Additional police needs to be deployed during the rush hours and at the station exits.

The root of the solution lies not in the circumstances of the case but in changing mind-sets. When boys and girls are treated equally from an early age and taught to respect each other, such crimes will automatically diminish. The gendered roles need to be broken down to open up the public space for people of all genders to occupy equally and the disparity relations need to be set right. Several respondents in this study suggested increasing the number of women bus drivers and a “between stops” request on public buses, where women passengers could be dropped.

Conclusion

For years, women have been celebrated as goddesses in Indian mythology. On the one side women in India are venerated as embodiment of goddesses and at the other side those same
women are discriminated against and often subjected to harsh and heinous forms of violence and aggression by the same men who worship them. This hypocrisy in the treatment of women is precisely what makes India unsafe for women. Many Indian women are thriving in the corporate world and are constantly breaking the impenetrable glass-ceiling. In this modern day India, it is imperative that the interests of women who make up one half of the population are safeguarded. Ancient ideas should have no place in the emerging India. The notion of women’s safety in India currently is a narrow one which focuses on security and defense and not safety as a natural right. Strict action needs to be taken in cases of illegal parking near street markets as this encourages the possibility sexual harassment in the space that gets blocked.

India is on the high growth trajectory, it must simultaneously ensure that all citizens have equal access to safety and security within its mega cities. City architects must have a clear understanding of constructing and managing public spaces taking into account the needs and safety of the female population and gendered patterns of usage. All Indian cites need to become “gender inclusive cities” and not just safer cities.

References
Kumari, V. (2014), “Problems and challenges faced by urban working women in India”, a dissertation submitted to the Department of Humanities and Social Sciences, National Institute of Technology, Rourkela.


Further reading


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

Steve Moore

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 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...
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, Killett 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-Klawsnik, 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 regretfully 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 their 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 inexpert 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 (Kirkeley 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; Killett 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 Killett 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 naive, 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.

References


About the author

Dr Steve Moore, RN, DMS, MSc and PhD, is an Independent Researcher, Practitioner and Consultant with particular interest in the causes, nature and extent of adult abuse in care homes. He previously worked for an English local authority as a commissioner of care services for older people where he completed both a Master’s Degree in Public Service Commissioning and a PhD based on empirical research exploring the extent, nature and contributory factors in the abuse of older people in private sector care homes. He is now undertaking continuing research into the causes and nature of abuse in care homes using one component of the methodology employed for the PhD, and by means of other methods, including an ongoing ethnographic study. Dr Steve Moore can be contacted at: stevenmoore580@gmail.com

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Safeguarding has become an important and significant role for nurses from all four fields of nursing. Arguably, with the number of vulnerable people on the increase this role is set to develop further in respect of accountability and responsibility. The changing face of policy and legislation is one that adds to the complexity that nurses confront in respect of decision-making and the understanding of their role in respect of protecting rights, as well as providing protection, for those who are at risk of exploitation or abuse. The area of safeguarding is one that is fraught with ethical dilemmas for nurses and requires sensitive and careful management.

In respect of safeguarding children, there is a fairly well-developed body of literature to support practitioners in their roles. However, this body of evidence in respect of safeguarding adults has been slower in its development and there is a limited guidance to support professionals and carers working with this population group. This is where this second edition book becomes a valuable and extremely informative source of reference. Its accessible format is one that makes the text interesting, thought provoking and engaging. Key topics are addressed starting with exploring the context of safeguarding, vulnerability and abuse. This leads logically into other chapters that explore more in depth issues such as ethical and professional frameworks, legal and policy provisions, interprofessional and interagency working and positive practice using a systems approach.

The chapters are supported by activities that promote critical thinking and the application of theory, highlighted within the text, to practice. The book promotes independent learning skills, provides case studies, guidance to further reading and details of useful resources. Each chapter is clearly mapped to the Nursing and Midwifery Council (NMC) Standards for Pre-registration Nursing Education Domains and the NMC Essential Skills Clusters.

This edition of the book has been updated to ensure it captures the changing face of the socio-political-legal arena encompassing this complex and important area of practice. I highly recommend that this book is adopted as essential reading for student nurses and it will also be of benefit to students in other health and social care disciplines. Similarly, it will also be a valuable resource for qualified and unqualified health and social care staff to inform their practice within this area.

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The Journal of Adult Protection
Evidence-based practice in relation to safeguarding adults

Number 2
73 Editorial
78 Learning from safeguarding adult reviews on self-neglect: addressing the challenge of change
   Michael Preston-Shoot
93 Reporting sexual violence on mental health wards
   Maíon Foley and Ian Cummins
101 The sexual street harassment battle: perceptions of women in urban India
   Jehangir Bharucha and Rita Khatri
110 Through a glass darkly: exploring commissioning and contract monitoring and its role in detecting abuse in care and nursing homes for older people
   Steve Moore
128 Book review

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