A Critical Analysis of Adult Safeguarding Practices in NHS Mental Health Services

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Contents

Acknowledgements

'It is good to have an end to journey towards; but it is the journey that matters in the end' (Ursula K. Le Guin)

As I reach the end of this incredible journey that has spanned almost a decade, my final task is to find the words to aptly convey the depth of gratitude and thanks I have for those who supported me along the way.

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Abstract

The abuse and neglect of adults at risk is increasingly recognised as a social problem in the U.K. Policy development for the protection of at risk adults has seen substantial growth since the publication of the *No Secrets* (2000) guidance. Despite cumulative evidence that NHS mental health services have been slow to engage with the national adult safeguarding agenda, there is a paucity of research in this area. The aim of this doctoral research was to explore and critically analyse the use and implementation of adult safeguarding practices in NHS mental health services.

A Grounded Theory (GT) approach was adopted to develop theory inductively through data collection and analysis. A total of sixteen participants were interviewed from within three NHS mental health trusts, including: 10 (62%) strategic leaders for adult safeguarding and 6 (38%) operational personnel. The results revealed three conceptual components central to the implementation of adult safeguarding in mental health, namely: *establishing structures, processes and procedures; challenges to effective implementation;* and *transition to a progressive future*.

Barriers invariably hamper the establishment of effective adult safeguarding practice within services, some of which are specific to mental health contexts. The findings of this research demonstrate a need for the development of multi-dimensional strategies that anticipate the contingencies of service contexts with greater consideration of the factors that inevitably impact adults at risk in mental health services.

List of Abbreviations

ADSS	Association of Directors of Social Services
AEA	Action on Elder Abuse
ASP	Adult Protection and Support Process
BPS	British Psychological Society
BSP	Basic Social Process
CAMHS	Child and Adolescent Mental Health Services
CEO	Chief Executive Officer
CHI	Commission for Health Improvement
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CRB	Criminal Records Bureau
CQC	Care Quality Commission
DBS	Disclosure and Barring Service
DH	Department of Health
DHSS	Department of Health and Social Services
EBP	Evidence Based Practice
EPPI	Evidence for Policy and Practice Information
GT	Grounded Theory
GTM	Grounded Theory Method
HMT	Hospital Management Team
HRA	Health Research Authority
LD	Learning Disability
LA	Local Authority
MARAC	Multi-Agency Risk Assessment Conference
MH	Mental Health
MIU	Minor Injury Unit
NASCIS	National Adult Social Care Intelligence Service
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
NIHR	National Institute for Health Research
NPSA	National Patient Safety Agency
NRES	National Research Ethics Service
NRLS	National Reporting and Learning System
OC	Organisation Change
OT	Occupational Therapist
PARIHS	Promoting Action on Research in Health Services
PCT	Primary Care Trust
PPIE	Patient and Public Involvement and Engagement
REC	Research Ethics Committee
R&D	Research and Development
SA	Safeguarding Adults
SAB	Safeguarding Adults Board
SAG	Safeguarding Adults Group
SG	Safeguarding
SUI	Serious Untoward Incident

Chapter One: Introduction

Chapter Overview

The following chapter is presented in two sections. The first section provides an introduction to the research topic, adult safeguarding in mental health; it presents the research aims and objectives, and provides an outline of the thesis structure. The second section of the chapter begins with an exploration of abuse and neglect from a historical perspective. Specifically, abuse and neglect within institutions for the 'mentally ill'[1] throughout the 18th and 19th centuries, and early reforms during the 20th century will be discussed. This is followed by critical discussion of contemporary evidence of abuse and neglect in mental health services. A further sub-section of the chapter presents an initial systematic search for empirical literature that considers adult safeguarding in mental health services, since the publication of the 'No Secrets' (2000) guidance. Discussion and exploration of the theoretical explanations offered within the identified literature, for the neglect of this phenomenon, is provided. The chapter concludes with identification of the potential areas that require empirical development and the research problem that will be addressed by the present study.

[1] The terms used in this chapter are consistent with the literature that is cited. The author acknowledges that these terms are no longer common usage terms (e.g. 'mentally ill', 'mental hospital', 'vulnerable adult').

1.1 Introduction and Overview of the Research

'Safeguarding adults' encompasses a range of activities that promote the safety and protection of people at risk of abuse and neglect throughout the U.K. (Department of Health, 2010; DH, 2014). In 2000, the *No Secrets* (DH, 2000) guidance proposed a framework for the implementation of coherent policies and procedures across multi-agency settings to protect *'vulnerable adults'* from abuse and neglect (DH, 2000, p. 8; ADSS, 2005). Following its introduction, an emerging evidence-base for adult safeguarding in many settings was highlighted; however, there were persistent concerns about the disengagement of NHS mental health services (DH, 2009; NPSA, 2006). Indeed, it was suggested that mental health services were *'slow to reform and reluctant to tackle the problem of abuse'* (Williams & Keating, 2000, p. 32).

Developments in the area of adult safeguarding have seen the introduction of a new legal framework within The Care Act for England and Wales (2014). Despite the inclusion of statutory Safeguarding Adults Boards (SAB)[2] in each local authority, and a wider consideration of prevention and personalised approaches to adult safeguarding, the development of effective multi-agency arrangements remains the predominant focus of this newly introduced guidance (DH, 2014; Stevens et al, 2017). There remains a considerable lack of specific guidance available to services about how to implement adult safeguarding practices within their respective organisations. Concerns about the participation of mental health services with the national adult safeguarding agenda prevail, with surprisingly low numbers of referrals

[2] Please see list of abbreviations on page ix

generated from within mental health inpatient settings (NASCIS, 2014). Despite this, relatively little is known about the use and implementation of adult safeguarding in NHS mental health services.

There is a clear and immediate need for empirical research in this area, which the present study aims to address. Table 1.1 provides details of the research activities that took place during the different stages of this research and outlines their associated uses and benefits. The table shows that there were a number of scoping activities carried out during Phase 1 of this research. This included an early review of existing literature on the topic of adult safeguarding in mental health, informal discussions with adult safeguarding practitioners, and the distribution of a national survey. Collectively these activities provided a contextual and conceptual understanding of the research problem and facilitated the development of the research aims and objectives presented below.

Table 1.1 Research Activity and Study

	Phase	Activity	Details, uses, and benefits
PRELIMINARY SCOPING PHASE	1	Literature Search	• Initial scoping of relevant literature provided a contextual understanding of the research problem • The knowledge gained informed the development of informal discussion questions and an on-line survey
	1	Informal Discussions	• Informal discussions familiarised the researcher with day-to-day adult safeguarding practices • Topical areas were identified • The knowledge gained informed the development of an on-line survey
	1	Online Survey	• An online survey provided an outline of the organisational structure of adult safeguarding leadership in 33 NHS mental health trusts • Lead practitioners in participating trusts were identified • Existing practices and activities being used in participating trusts were identified • Practices and activities undergoing development in participating trusts were identified • Difficulties with the implementation and development of adult safeguarding practices were identified • A snapshot of the varying stages of development and implementation was gained • Permission to contact research participants for future participation was sought • The need for in-depth exploration of individual and trust perspectives was revealed and as such the need for a qualitative empirical focus was identified • Demographic information used to purposively select participating trusts for a Grounded Theory Study
PREDOMINANT EMPIRICAL PHASE	2	Planning and Preparation	• A circular qualitative research approach was selected for its relevance to the development of the study, via a process of elimination • Semi-structured interview schedules were drafted using knowledge gained during phase 1 • A research proposal was developed and submitted for Independent Peer Review • NHS Ethics approval was granted and access to 3 Trusts was permitted • The post-graduate certificate in research methods (PgCRM) was completed • The project was successfully transferred from MPhil status to PhD • The philosophical foundations of the research were established providing theoretical understanding of the theory construction that would follow
	2	Grounded Theory Study	• A substantive theory of adult safeguarding implementation in three NHS mental health trusts was developed • During the course of theory construction, 16 safeguarding practitioners were interviewed • Constructivist Grounded Theory (CGT) principles governed all methods of data collection and analysis including; interviewing techniques, sampling and participant selection, coding and constant comparison, diary entries, field notes and memo writing, theory development and construction, and narrative presentation • Three major categories were derived from the interview data and combined to provide a conceptual overview of adult safeguarding in NHS mental health trusts. These were: *establishing structures, processes and procedures; challenges to effective implementation;* and *transition to a progressive future*.
	2	A Realist Review of Literature	• A retrospective realist review of literature was undertaken • Using advice and guidance and additional literature an 'Initial Programme Theory' was constructed • Nineteen studies were used to compare practice based evidence to the initial programme theory • A narrative discussion of the findings was presented • The findings of the studies undertaken were considered in relation to the literature reviewed during stages 1 and 2 of this research

1.1.1 Aims and Objectives

The following section presents the aims and objectives of the present research, which represent the overarching goals of this project. Additional aims and objectives are discussed within individual sections, which were developed to meet the needs and requirements of specific study phases.

Research main aims**:**

A. To explore the implementation, development, and use of adult safeguarding practices and procedures in NHS mental health services
B. To improve understanding of the structures and processes involved in keeping adults safe in mental healthcare and identify whether the challenges faced differ to those in other settings

Research objectives**:**

1. To explore and critically analyse stakeholders' experiences and perspectives of implementing adult safeguarding practices, procedures and policies and their use in NHS mental health trusts
2. To identify, explore and critically analyse stakeholders' experiences and perspectives of the main barriers to developing adult safeguarding practice in NHS mental health trusts
3. To identify, explore and critically analyse the specific circumstances under which adults with mental health difficulties are safeguarded from the perspectives of those involved

4. To critically review literature relevant to the implementation or development of adult safeguarding practice across NHS health services

1.1.2 Original Contribution to Knowledge

The original contribution to knowledge made by the present research is as follows:

- A realist review of literature that identifies the evidence-base for the implementation of adult safeguarding within NHS health services
- A substantive theory of the implementation of adult safeguarding in three NHS mental health trusts
- Identification of the barriers and factors that facilitate the effective implementation of adult safeguarding practices in NHS mental health trusts

1.1.3 Thesis Structure

This thesis features seven chapters, including the current chapter, each illuminating a crucial stage of development in the undertaking of the present research. The second chapter discusses in detail a number of scoping activities that were undertaken to aid the identification of the aims and objectives of the second phase of this research. The activities discussed include informal discussions with safeguarding practitioners and the results of a national survey of NHS mental health trusts in England and Wales (Fanneran et al, 2013). The survey results revealed that the implementation of adult safeguarding in mental health was in its infancy and barriers to practice were abundant (Fanneran et al, 2013). The ability to explore these barriers was somewhat limited by the questionnaire design typical of a survey methodology; hence, a qualitative approach

was deemed the most suitable for the subsequent phase of the research. The chapter concludes with articulation of the aims and objectives of the qualitative study.

The learning journey of the researcher in attempting to establish the philosophical orientation of the qualitative study is captured in the third chapter. In particular, consideration of the applicability of relevant qualitative approaches to the needs of the research is discussed, along with reasons for non-selection. Similarly, there is examination of relevant research paradigms and the reasons for exclusion or non-applicability of those that were examined, is provided. The paradigmatic framework of the study is illustrated and the specific justifications for selecting a Grounded Theory (GT) approach are outlined. This is followed by discussion of the constructivist orientation of the GT approach adopted.

The fourth chapter begins with a discussion of the steps involved in the GT process used in the qualitative study. It continues with a detailed discussion of the methods used to undertake the qualitative study in accordance with the principles of the Grounded Theory Method (GTM). This includes strategies and methods used to select study participants and the methods used for data collection, specifically semi-structured interviews and note taking. This is followed by discussion of the coding techniques used to analyse the interview data. This includes line-by-line, incident-to-incident, focused, and theoretical coding and the integration of memos. Throughout this section the researcher uses extracts from the study data to illustrate these processes. The chapter

concludes with a section on research ethics, which provides essential information about the risks to participants and measures taken to minimise these and ensure that ethical compliance was maintained throughout.

The fifth chapter presents the findings of the qualitative study and begins with discussion of participant demographics. This is followed by a conceptual overview of the substantive theory derived from the qualitative data. The chapter continues with a detailed discussion of the theoretical narrative, which is organised across three major categories, namely: *establishing structures, processes and procedures, challenges to effective implementation,* and *transition to a progressive future*. Within each major category are numerous minor categories all of which are seamlessly interwoven into the narrative to illustrate the use and implementation of adult safeguarding in three NHS mental health trusts. The chapter concludes by highlighting a shift in mental health that indicates a transition from a former internalised culture to an increasingly more transparent outlook.

Consistent with the GT methodology utilised within the qualitative study, the sixth chapter features a retrospective literature review of empirical research in the area of adult safeguarding within mainstream NHS health settings. It begins with an introduction to the realist review method used to undertake the literature review, outlining its particular suitability to the research area. This is followed by presentation of the method used in the review, which includes: *the scope of the review, establishing the initial*

programme theory, systematic searches, and *data abstraction and synthesis*. The chapter continues with detailed discussion of the review findings, with a specific focus on determining whether practice based evidence suggests that the intended programme theory for the implementation of adult safeguarding is successful or not. Discussion of the findings and the strengths and limitations of the review are highlighted and the chapter concludes by highlighting the key messages illuminated within the review.

A general discussion of the research discussed in this thesis is presented in the final chapter. It begins with an integrated discussion of the findings of the qualitative study in relation to the literature reviewed in Chapters 1 and 6, and has been organised according to the research aims and objectives. This is followed by discussion of the strengths and limitations of the research, which are specifically related to the exploratory nature of the research topic, the methodology adopted, and the anticipated impact of this work. The chapter continues with an indication of the implications of the research findings and recommendations for practice development. The chapter also includes a dissemination plan, with details of anticipated publications and future research development. The chapter concludes with a précis of the key messages of this doctoral research.

1.2 Origins and Scope of the Research Problem

1.2.1 Historical Origins

Abuse and Neglect in Mental Health Services: A Historical Perspective

People living with mental illness have endured a longstanding history of abuse and neglect within our society. Prior to the 19th century, individuals living with mental illness were assumed to be *'habitually disordered, malicious base creatures'* and consequently subjected to abuse and punishment by family members (Koenig, 2005; Millon, 2004; Kraeplin, 1962, p.24). Indeed, a census of the 'mentally ill' in the 1870's, revealed that one-fifth of 164 persons living with mental illness had been kept at home in *"narrow, dark, damp, stinking lockups"* (Shorter, 1997, p.3). Individuals who were not cared for by family members received similar treatment in private workhouses, poorhouses or madhouses (Millon, 2004; Jones, 1993). People living with mental illness were commonly restrained by the arms, legs, and neck ensuring that they were limited to either a fixed standing or seated position (Millon, 2004). It is said that *'their endless physical suffering made their plight worse than that of the most vicious criminals or murderers'* (Millon, 2004, p.84).

In the 19th century, legislative advancements made some improvements to conditions for those living with mental illness. The Lunatics Act (1845) stipulated that all UK counties should provide adequate asylum for the mentally ill. It proposed that asylum practices should involve *'the minimal use of physical restraint'* thereby creating a more

humanitarian environment (Butler & Drakeford, 2003, p.10). Asylums, thus, provided a solution to problems of social control as well as satisfying the moral consciousness of an evolving society. For example, The Manchester Lunatic Hospital was noted for its *'tender treatment of the insane'*, while The Retreat at York developed *'moral treatment'* for its inpatients (Jones, 1993, p.23). However, as the demand for asylum places increased, small-scale therapeutic buildings began to resemble large-scale custodial warehouses. Consequently, the moral treatment regimens upon which they had been established deteriorated, resulting in a drift towards '*impersonality, regimentation, and institutionalisation of routine*' (Butler & Drakeford, 2003, p.12).

In 1930 the Mental Treatment Act was introduced, which allocated the responsibility for asylums to the medical profession (Jones, 1993). Asylums were aptly renamed 'mental hospitals' and greater emphasis was placed upon the medical needs of inpatients. Despite this promising move, the majority of inpatients remained compulsorily detained and the hospitals themselves were *"really little different from the Victorian asylums"* (Rogers and Pilgrim, 1996, p.61). Indeed, a review of mental health service provision (Herd, 1939) concluded that while the 1930 Mental Treatment Act had positively influenced the situation, it had not been fully embraced throughout the country (Jones, 1993). It further proposed that a complete overhaul of existing legislation was required to align it with developments in the treatment of psychoneurosis (Jones, 1993).

The National Health Service (NHS) was founded in 1948 and incorporated mental illness and mental deficiency hospitals within its remit. In the post-war period that followed the situation in mental health worsened. A rapid increase in bed occupancy placed increasing pressure on mental hospitals resulting in deleterious conditions for patients. Outpatient clinics were said to be ill equipped and under-staffed with inadequately trained personnel. Indeed, it was suggested that some mental hospitals were *'very near to a public scandal'* (Klein, 1995, p.80). Furthermore, the stigma associated with mental illness of previous years had prevailed highlighting an urgent need for mental health education. One event, in particular, is said to have sparked fervent public debate regarding conditions in UK mental hospitals at this time (Butler & Drakeford, 2003; Martin, 1984; Jones, 1993).

Sans Everything: A case to answer (Robb, 1967) was published following an appeal to *The Times* newspaper for a national investigation into the ill treatment of geriatric patients throughout the country. An influx of public responses highlighted many instances of *'callous indifference to patients, exploitation, rough handling, removal of glasses, hearing aids, dentures and other indignities'* in mental hospitals across the UK (Korman & Glennerster, 1990, p.15). The Ministry of Health commissioned a series of inquiries to investigate the findings of the *Sans Everything* report. It was concluded that the majority of allegations were either '*totally unfounded or grossly exaggerated*', albeit an immediate need for an investigation into suspected ill treatment in healthcare services across the UK was highlighted (Butler & Drakeford, 2003, p.42; Martin, 1984).

A subsequent inquiry was commissioned at the Ely Hospital, Cardiff, following allegations of petty theft by staff members and the mistreatment of four specific patients. A charge nurse named John Edwards was identified as the main protagonist of the abuse uncovered. It was reported that Mr. Edwards persistently threatened and intimidated patients, regularly administered physical beatings and on one occasion hosed a number of patients down with cold water as a form of bathing (DHSS, 1969). Although the inquiry committee concluded that much of this unsavoury behaviour was attributable to an *"old fashioned and unsophisticated"* approach to nursing, it was suggested that a series of management failures including the recruitment of suitably qualified staff and a serious lack of training provision, cumulated in the corruption of care at Ely (DHSS, 1969).

The findings of the Ely Inquiry were somewhat inconsequential, although it achieved a number of supplemental successes. For example, the inquiry committee successfully placed responsibility upon the Ministry of Health to use Ely to *'illustrate a defect in the structure of the Health Service'* (Crossman, 1977). In addition, the dedication of the inquiry team resulted in the introduction of new and improved standards for conducting inquiries. Ely thus marked the beginning of reform in UK mental health hospitals with a total of 18 subsequent inquiries commissioned between 1968 and 1980 (Walshe & Higgins, 2002; Butler & Drakeford, 2003). Of the 18 inquiries, 12 were conducted in psychiatric hospitals, 4 in 'mental handicap' hospitals and 2 were conducted within combined services (Butler & Drakeford, 2003).

The Farleigh Hospital Inquiry was established following allegations of patient ill treatment that resulted in nine male nurses being charged with criminal offenses, three of whom received prison sentences (Report of the Committee of Inquiry into Farleigh Hospital, 1968). Due to the already concluded criminal investigations the inquiry committee focused their attention on the administration of the hospital and its conditions between 1967 and 1968. An inspection of the clinical records of the Responsible Medical Officer, Dr. Knappe, revealed his abysmal view of 'severely mentally handicapped' patients indicating his surprise that *'such low grades being so filthy dirty and animal-like in habits'* could appreciate the bright colours and comforts of a newly decorated building (Report of the Committee of Inquiry into Farleigh Hospital, 1968, p. 13). Dr. Knappe also considered himself exempt from responsibility for patient welfare other than those who were detained under the Mental Health Act (1959) and claimed no knowledge of the unsavoury practices on the North Ward, where the criminal offenses had taken place (Report of the Committee of Inquiry into Farleigh Hospital, 1968).

The inquiry committee heard evidence from one charge nurse who believed it necessary "*to hit a patient who is violent"* or *"who is attacking a member of the staff or another patient"*. He believed he was *'doing his job, and doing it properly'* and that actions such as these were necessary on the North Ward where patients' needs were substantial (Report of the Committee of Inquiry into Farleigh Hospital, 1968, p. 19). The inquiry also uncovered thirteen patient deaths, over a ten year period, that were not

reported to the coroner and numerous complaints of injuries and harm to patients made by family members and student nurses that were '*brushed aside*' (Report of the Committee of Inquiry into Farleigh Hospital, 1968, p. 21). The multiple failings highlighted by the inquiry committee included: non-compliance with national trends in care; the absence of psychiatric leadership; unresolved disputes between senior management; a lack of medical supervision and complete control by nurses; consultants' discretion about the reporting of patient deaths; staff factions and incompatibility; substandard conditions on North Ward; and inadequate staff training.

The Whittingham Hospital Inquiry (1972) followed soon after and was established following allegations of victimisation, ill-treatment, and mal-administration in 1969. These allegations resulted in two male nurses being convicted of theft and another convicted of manslaughter (Report of the Committee of Inquiry into Whittingham Hospital, 1972). The scale of the inquiry was substantial with evidence presented to the committee by eighty-five witnesses over a period of eighteen days. Allegations of patient ill treatment were predominantly associated with care provision on four long-stay wards and the majority related to a single female ward (Report of the Committee of Inquiry into Whittingham Hospital, 1972). Patients on the ward were subjected to multiple instances of cruel and callous treatment that included: inadequate occupation; a bread and jam diet; inappropriate eating utensils; being served slops of food; restriction of fluids; inappropriate dressing and bathing rituals; being locked outside in inappropriate clothing in all weathers; and locking patients away as a form of behaviour management.

Even more disturbing were, the allegations made about the treatment of patients by the nurse who had been convicted of manslaughter in the preceding criminal investigation. Indeed, witness accounts suggested the nurse in question regularly used 'wet towel treatment' whereby a wet towel was twisted around a patient's neck until they fell unconscious (Report of the Committee of Inquiry into Whittingham Hospital, 1972, p. 12). The same nurse was also accused of being involved in an incident with methylated spirits, which was poured onto patients' clothing and set alight. Despite the vehement denial of these allegations by the alleged nurses, the evidence given was deemed trustworthy and accepted by the inquiry committee (Report of the Committee of Inquiry into Whittingham Hospital, 1972). A further significant finding of the Whittingham Hospital Inquiry (1972) was the scale of fraud evident at the hospital. Substantial amounts of patients' money was unaccounted for and evidence provided by student nurses indicated that goods purchased on behalf of patients did not always tally with what was received (Martin, 1984).

Events involving the death of patients at the Napsbury Hospital and South Ockendon hospital in London also prompted further investigation in the wake of Ely. A professional investigation at Napsbury revealed the use of unorthodox methods of treatment introduced by an ambitious consultant psychiatrist that resulted in *'unkindness and unintentional cruelty'* due to the intensity and isolation with which they were implemented (Martin, 1984; Napsbury Hospital Report, 1973). In particular, it was

highlighted that while medical leadership was considerably invested in patient welfare, the intensity of the regime resulted in unacceptably low physical conditions and a lack of choice (Martin, 1984). Similarly, the abuse of patients at South Ockendon echoed those seen at Farleigh, Whittingham and Napsbury and involved multiple instances of physical assault of patients including slapping *'round the face'* to teach patients to behave (Report of the Committee of Inquiry into South Ockendon, 1974, p. 26). There was evidence of considerable negligence on the part of nursing staff to keep patients safe, which resulted in patient fatalities.

The inquiry findings also placed particular emphasis on the punitive regime that had been implemented in Cypress Villa (Martin, 1984; Report of the Committee of Inquiry into South Ockendon Hospital, 1974). Life in side rooms was described as *'completely lacking in dignity and incapable of justification'* (Report of the Committee of Inquiry into South Ockendon Hospital, 1974, p. 50). All new patients were secluded on admission and expected to eat their meals without the aid of utensils whilst sitting on mattresses on the floor. Patients were often secluded in side rooms for weeks at time as a form of punishment without furniture and clothed only in pyjamas with the trouser cord removed. Dr. Harfst who was responsible for the regime in Cypress Villa was described as having an enthusiasm for security that *'was almost obsessional in its intensity'* (Report of the Committee of Inquiry into South Ockendon Hospital, 1974, p. 48).

Erving Goffman (1961) notably asserted that the effects of institutional life on the individual were detrimental and resulted in the *'mortification of the self'* or defacement of one's identity (Goffman, 1961). He proposed that structures and procedures administered in *'total institutions'* such as the *'ritual bath'* shaped the new identity of an inhabitant. He further suggested that practices such as shock treatment and psychosurgery were forms of physical assault and described psychotherapy as an elaborate means of disabling a patient's defenses (Jones, 1993). British psychiatrist Russell Barton similarly purported that long-term mental patients had two illnesses: one that caused their admission and the other a result of institutional practices (Barton, 1959). Goffman concluded that the structures and procedures of 'total institutions' were entirely anti-therapeutic and solely gratified the needs of relatives, police, judges and psychiatrists (Jones, 1993).

Mental Health Policy and Reform

The uncovering of scandals in mental health and recognition of the ill effects of institutional life compelled changes to mental health policy in the UK. In 1959 the Mental Health Act was introduced, which outlined new ways of working with mentally disordered persons with respect to their property and affairs. In particular, emphasis was placed upon the importance of community care services for people living with mental illness, with the implicit suggestion that local authorities should be responsible for making this provision (Mental Health Act, 1959). The need for community care services was further emphasised within the *Hospital Plan for England and Wales*

(Ministry of Health, 1962). Specifically, the development of general medicine and acute care was deemed the priority, which would require a dramatic reduction in the number of long-term beds in UK mental hospitals, hence an alternative would be required (Jones, 1993).

Simultaneous research developments in mental health further demonstrated the need for alternative care provision. Empirical studies had begun to demonstrate higher risks associated with long-term hospital care and the progression of mental illness (Szasz, 2012). In addition, the discipline of psychiatry came under increasing criticism for its excessive use of diagnostic categories and a general disregard for the sociological factors associated with mental illness (Rosenham, 1975; Bateson, 1972; Laign & Esterson, 1964). These factors collectively led to the publication of *Hospital Services for the Mentally Ill* (DHSS, 1971), which provided the first official guidelines for the phasing out of large mental hospitals. A subsequent publication *Better Services for the Mentally Ill* (DHSS, 1975) outlined a number of objectives with which this would be achieved, as outlined in Table 1.2. Table 1.2 shows that the focus of these objectives was the development of community services, the relocation of specialist services to local areas, and improvements to staffing provision and inter-agency working.

[3]Table 1.2. Policy objectives - Better Services for the Mentally Ill (DHSS, 1975)

	Policy Objective
1.	Expansion of local authority residential, day care, and social work support services
2.	Relocation of specialist services in local settings
3.	Establishment of the correct organisational links between day and residential care services, between specialist teams and primary care services, between local authority administrators and planners and between professionals and non-professionals
4.	Staffing improvements which would make possible assessment, review, early intervention and preventative work

Asylum closures were subsequently ongoing throughout the 1980's during which time community care services were substantially developed (Boardman, 2005). The development of community-based care and its segregation from hospital-based care led to a number of financial, professional and geographical difficulties (Boardman, 2005). In addition, the emergent boundary between health and social care services prevails to the present day and resulted in two competing models of care for the mentally ill. The medical model, predominantly influenced by psychiatry, focused on the use of psychotropic drugs to stabilise patients who were admitted to acute services (Boardman, 2005). In contrast, the social care model focused on the social problems associated with mental illness and advocated the use of family-centred or behaviourist approaches to treatment (Boardman, 2005).

[3] Please see Appendix 1a for a list of tables

Abuse and Neglect: Recognition of the Problem in Mental Health

Following a surge of public interest in the phenomenon of *'Granny Battering'* in the USA during the late '70's (e.g. Baker, 1975; Burnston, 1977), the issue of elder abuse came under the research spotlight in the UK. Efforts to explore and understand the nature and scope of elder abuse (Pilemer & Wolf, 1986; Bennett & Kingston, 1993; Bennett, Penhale & Kingston, 1997; Declamer & Glendenning, 1997; Eastman, 1984) resulted in increasing recognition that this was an issue that required public intervention. In 1993 the Social Services Inspectorate and the Department of Health issued the first official guidelines for the development of interagency policies to combat elder abuse (DHSSI, 1993). The development of such policies was not a statutory requirement and resultantly did not become a priority for all authorities (Declamer & Glendenning, 1997).

In 1998 the Department of Health (DH) declared their intention to provide better protection and support for vulnerable adults (DH, 1998a, 1998b). By the end of 1998, almost 80% of local authorities and NHS trusts had developed policies for the protection of vulnerable adults. During the implementation of such policies at the Nuffield Foundation Trust, signs of resistance were observed in mental health services (Brown & Stein, 1997). More specifically, mental health professionals expressed dissatisfaction with the applicability of generic policies and procedures in mental health, due to the specific challenges associated with mental health service-users and best interest decision-making (Brown & Keating, 1998).

In 2000 the *No Secrets* (DH, 2000)[4] guidance was published providing national services with a framework for implementing coherent multi-agency policies and procedures to safeguard vulnerable adults (DH, 2000). It importantly stated that *'there can be no secrets and no hiding place when it comes to exposing the abuse of vulnerable adults'* (DH, 2000, p.1). The aim of this guidance was to *'create a framework for action within which all responsible agencies work together'* (DH, 2000, p.6). It emphasised that while the primary aim is to prevent abuse, situations may occur where preventative strategies fail and it is the responsibility of partner agencies to ensure that robust procedures are in place to deal with reported incidents of abuse & neglect (DH, 2000). The No Secrets Guidance (DH, 2000) clearly defined the types of abuse and neglect that may occur and who may be vulnerable. It identified a vulnerable adult as a person *'who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation'* (Lord Chancellors Office, 1997).

Abuse occurs when an '*individual's human and civil rights'* are violated *'by any person or other persons'* (DH, 2000, p.9). It further highlighted the need to consider whether abuse is a '*a single act or repeated acts'*, is '*physical, verbal or psychological',* is *'an act of neglect or an omission to act'* or if the vulnerable person has been persuaded *'to enter into a financial or sexual transaction to which he or she has not consented, or*

[4] The framework introduced within the No Secrets guidance was replaced with a clearer legal framework published in the Care Act (2014). Guidance provided to health services for the implementation of adult safeguarding is discussed in Chapter 6 of this thesis.

cannot consent' (DH, 2000, p.9). It also emphasised that 'a*buse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it'* (DH, 2000, p.9). In determining whether an adult is vulnerable or has been subject to a human and civil rights violation there are a number of additional considerations that must be made. An adult has the right to *'liberty and security (freedom of choice)'* and *'respect of privacy in family life'* (Human Rights Act, 1998). Vulnerable adults must therefore feel empowered to make their own choice where possible (Whitelock, 2009).

Following the publication of the *No Secrets* guidance (DH, 2000), improvements to adult safeguarding practice were highlighted in many settings (Appleton, 2009; Cambridge & Parkes, 2006); however, evidence indicated that the abuse and neglect of mental health service-users remained prevalent (Mind, 2004; Mind, 2007; NPSA, 2006). For example, investigation of the suspected abuse of older adults on the Rowan Ward, at the Whittington Hospital (Commission for Health Improvement, 2003), revealed that incidences of '*hitting, slapping, stamping on feet, thumb twisting, intimidating language, and emotional abuse in the form of restricting food and playing on known anxieties of patients'*, had been ongoing for several years (CHI, 2003, p.8). Unexplained injuries were also uncovered along with several factors associated with an increased risk of abuse, including *'a closed inward looking culture'*, staff factions, and weak management at a ward level and within the locality (CHI, 2003, p.9).

Evidence of abuse was also reported in a survey conducted by Mind (2004) to assess hospital conditions for patients accessing NHS mental health wards. It was revealed that, fifty-one percent of respondents (of a total of 335) reported verbal or physical harassment, with twenty percent reporting actual physical assault (Mind, 2004). Sexual safety was also a concern with eighteen percent of survey respondents reporting sexual harassment during their hospital stay and a further five percent reporting actual sexual assault. Surprisingly, only thirty-nine percent of respondents who were the victim of verbal, violent, racist or sexual abuse / harassment reported the incident to a staff member (Mind, 2004). The explanations offered by respondents suggested there was a fear of not being '*taken seriously'* and a lack of confidence in staff members to take the appropriate action (Mind, 2004, p.9).

A National Patient Safety Agency (NPSA) report entitled 'With Safety in Mind' (NPSA, 2006) also highlighted the importance of addressing patient safety in mental health services across the UK. Analysis of almost 45,000 incidents recorded between 2001 and 2005 through the NHS National Reporting and Learning System (NRLS) is presented within the report (NPSA, 2006). The report revealed many important issues regarding the prevention of falls, the management of disruptive or aggressive behaviour and sexual safety on mental health wards (NPSA, 2006). The need to implement effective interventions to improve safety and reduce risk in areas such as medication, sexual safety and physical safety on acute wards, was acknowledged within the report (NPSA, 2006). However, the overall lack of compliance with adult protection policy and procedures on mental health wards was largely overlooked (Johnson, 2006).

Analysis of adult protection referrals in two English local authorities further evidenced a lack of compliance with adult protection in mental health services (Mansell, 2009). Of 6148 adult protection referrals recorded between 1998 and 2005, just 3% were for people with mental health problems (Mansell, 2009). In view of the heightened vulnerability of this client group (DH, 2009), this number is strikingly low. Responses to the *Consultation on the Review of the No Secrets Guidance* (DH, 2009) also indicated that there were concerns regarding incident reporting within mental health services. More specifically respondents suggested that the attendance of NHS mental health trusts at safeguarding meetings was inconsistent and safeguarding referrals for people with mental health problems were not representative of this client group (DH, 2009). Despite surmounting evidence of the prevalence of abuse and neglect among mental health service users, and the dilatory approach in addressing this issue adopted by service providers, this area has received little attention.

1.2.2 Consulting the Research Literature

During the planning stages of the present study, the breadth of the research topic and potential areas of interest were discussed during research supervision. A decision was made to conduct a preliminary literature search, to determine whether existing empirical literature offered insight into the apparent dilatory approach to implementing adult safeguarding adopted by NHS mental health services. The aim of the search was to identify and critically examine literature that focused specifically on adult safeguarding or protection in mental health services since the publication of the 'No Secrets' (2000) guidance. The search for literature was conducted systematically using MetaLib®,

which facilitated a meta-search of the electronic databases and resources listed in Table 1.3. Table 1.3 also provides a list of the Boolean phrases and search strings used during the literature search. The search aimed to identify a wide range of empirical papers published from 2000[5] to 2010[6]. Grey literature was also explored due to a suspected lack of empiricism in the area.

Table 1.3. Boolean phrases, search strings and data sources used during the preliminary literature search

Boolean Terms and Search Strings	Databases	Grey Literature Sources
1. Adult AND safeguarding OR protection AND mental health AND service* OR setting* AND NHS 1.1. Practice* OR procedure 2. Abuse* OR neglect* AND mental health AND service* OR setting AND NHS	➢ CINAHL ➢ Cochrane Library ➢ EBSCO ➢ Google Scholar ➢ Medline ➢ Psycharticles ➢ PsychINFO ➢ Pubmed ➢ Social Care (SCIE)	➢ DoH ➢ Mind ➢ Rethink ➢ NAU ➢ NRLS ➢ Community Care

[5] 2000 is the year the *No Secrets* guidance was published.

[6] This search was re-run in January 2017 to check for recently published material and again in June 2019.

Search Results

A total of 144 abstracts were identified through the initial search process. Assessment of paper titles reduced this number to 39 abstracts and following removal of duplicates this number was further reduced to 16. Exploration of titles and abstracts resulted in 6 full-text papers being obtained. Backward chaining (hand searching of reference lists) and the researchers continuous reading around the area of adult safeguarding during the first six months of study, identified a number of additional articles that are cited within the following discussion. Table 1.4 lists the key commentaries on the topic that were identified during early literature searches. The table shows that the identified sources included: 6 commentary pieces, 1 editorial, 1 book chapter and 1 report. As the purpose of this search was to contextualise the research problem during the early stages, just two guidance documents are referred to in this section. Discussion of guidance documents relevant to the research topic is discussed in Chapter 6 of this thesis.

Table 1.4. Key sources of literature identified during the preliminary search

Author	Title	Article Type	Article Source
	ARTICLES		
Faulkner (2005)	*Institutional conflict: the state of play in adult acute psychiatric wards*	Commentary	The Journal of Adult Protection
Galphin & Parker (2007)	*Adult protection in mental health and inpatient settings: an analysis of the recognition of abuse and use of adult protection procedures in working with vulnerable adults*	Commentary	The Journal of Adult Protection
Minshull (2004)	*Avoiding systemic neglect and abuse in older people's inpatient mental health care settings*	Commentary	The Journal of Adult Protection
Stanley & Flynn (2005)	*Special issue on mental health*	Editorial	The Journal of Adult Protection
Whitelock (2009)	*Safeguarding in mental health: towards a rights-based approach*	Commentary	The Journal of Adult Protection
Williams (2002)	*Public law protection of vulnerable adults: the debate continues, so does the abuse*	Commentary	Journal of Social Work
Williams & Keating (2000)	*Abuse in mental health services: some theoretical considerations*	Commentary	The Journal of Adult Protection
	BOOK CHAPTERS		
Williams & Keating (1999)	*Abuse of adults in mental health settings.* In: Institutional Abuse: Perspectives Across the Life Course. Eds. N.Stanley, J. Manthorpe, B. Penhale.	Chapter	London: Routledge
	REPORTS		
Department of Health (2009)	*Safeguarding Adults: Report on the consultation of the review of 'No Secrets'*	Report	HMSO
	GUIDANCE DOCUMENTS		
Department of Health (2000)	*No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*	Practice Guidelines	HMSO
Association of Directors of Social Services (2005)	*Safeguarding Adults: A national framework of standards for good practice and outcomes in adult protection work*	Practice Guidelines	ADSS

Findings

The findings of the preliminary literature search indicate that the failure of NHS mental health services to engage with the adult safeguarding process is a complicated issue with a number of possible causes and explanations (DH, 2009; Whitelock, 2009). The causes and explanations identified within the literature have been organised across four categories, namely: *policy, legislation and a translational gap; social inequalities and power differentials; institutional abuse and staff complacency; public protection and the criminal justice system*. Despite the use of evidence to support the theoretical explanations provided within key-articles, none were empirical studies.

Policy, Legislation, and a Translational-Gap

The interpretation and implementation of policy and legislation in practice settings is identified as a major issue for adult safeguarding and consideration of the factors that influence practitioner understanding in relation to these is highlighted. As aforementioned the No Secrets Guidance (DH, 2000) highlights the vulnerability of an individual *'who is or may be in need of community care services by reason of mental or other disability'* (Lord Chancellors Office, 1997, p.8). A vulnerable adult has the right to *'liberty and security (freedom of choice)'* (Human Rights Act, 1998, Article 5, p.1) with the responsibility of ensuring their right to 'choice' is upheld resting with the practitioner (Whitelock, 2009). Mental capacity is crucial in determining a person's ability to choose (Hart, 2008; Gearty, 2007) and is further complicated when fluctuating states of capacity

are present such as those common to individuals living with mental illness (Williams, 2002; Whitelock, 2009).

Despite the provision of a framework for action within policy guidance and legislation to improve professional decision making in this area (DH, 2009; Mental Capacity Act, 2005), allegations of abuse are often overlooked due to issues concerning the balance between individual rights and professional and ethical duties (Galphin & Parker 2007; Williams, 2002). For example, the concepts of autonomy and protection, despite the relative merits of both in the provision of quality care, are not synonymous (Galphin & Parker, 2007; Thompson, 2001). The terms ‘adult protection’ and ‘vulnerable adult’ may imply dependence on statutory services, whereas autonomous self-determination reflects an ideology of empowerment (Williams & Keating, 2000; Nelson & Prilleltensky, 2005). Such dichotomies are likely to impact practitioner views and responses to abuse allegations with the risk of inadequate support being provided if one concept is of greater ideological value than the other (Galphin & Parker, 2007).

In the UK, the implementation of organisational policy that supports target-focused approaches to practice is greatly influenced by managerial techniques drawn from the business sector (Newman, 2001). Such approaches may influence the management of service-users by healthcare professionals as opposed to facilitating collaborative alliances that support the development of autonomous recognition of their individual

rights, particularly within the remit of adult protection (Galphin & Parker, 2007). Resultantly abuse interventions are likely to prioritise the needs and requirements of the organisation overlooking the need for multi-agency involvement. Service-user experiences indicate that abuse allegations are often contained or dealt with in-house and not considered within the remit of adult protection (Whitelock, 2009). Indeed, the National Patient Safety Report (NPSA, 2006) documents 122 allegations of incidents relating to sexual safety concerning both staff and other service-users in mental health, none of which were recognised as sexual or adult abuse or led to criminal proceedings (NPSA, 2006). The *Abuse of Vulnerable Adults National Report* (NASCIS, 2014) further highlights that <2% of all referrals from 132 councils in England were generated from within mental health inpatient settings (NASCIS, 2014).

The development of multi-agency approaches that prevent and challenge abuse and provide adults at risk with a means to safely voice their concerns has been the focus of national policy development for adult safeguarding in the UK (DH, 2000; DH, 2014). Nevertheless, the development of health policy for the provision of care generally does not necessarily reflect this ideal. For example, the Care Programme Approach (CPA) (DH, 1990; DH, 2006), which is central to care planning and service delivery, promotes a cohesive approach to the delivery of healthcare between health and social care providers. The importance of adult protection is recognised within CPA (DH, 1990; DH, 2006); however *No Secrets* (DH, 2000) and the need for inter-agency provision for adult safeguarding are not explicitly acknowledged (Galphin & Parker, 2007). Due to the

priority given to initiatives like CPA within mental-health services, disengagement with the establishment of effective multi-agency arrangements for adult safeguarding, is potentially symptomatic of this oversight (Galphin & Parker, 2007).

Galphin & Parker (2007) highlight a number of misconceptions that exacerbate this issue further within mental health services. For example, there is an incorrect assumption that homogeneity exists between health and social care professionals who have a shared understanding of what constitutes adult abuse and the amalgamation of the words *health* and *social* will result in a unified approach to practice across services (Galphin & Parker, 2007). It is suggested that in order to bridge this gap a clear understanding of how multi-agency adult safeguarding arrangements interact with the wider care policy and legal framework is required (Galphin & Parker, 2007). Some researchers argue, however, that despite pursuit of a unified multi-agency approach for adult safeguarding; contextual issues will prevail in settings such as mental health that could be considered abusive by their very nature (Galphin & Parker, 2007; Williams & Keating, 1999; Williams & Keating, 2000; Whitelock, 2009).

Social Inequalities and Power Differentials

The inextricable link between social inequalities and mental illness is well documented with literature highlighting the impact inequalities have on service-user experience and engagement with services (Williams, Watson, Smith, Copperman & Wood, 1993;

Williams & Keating, 1999; Williams & Keating, 2000). For example, some mental health service-users have a history of poverty or physical and sexual abuse that is directly related to their experience of inequalities associated with gender, race, sexuality and age (Williams & Keating, 1999). Exposure to such inequalities may be compounded by a diagnosis of mental illness, resulting in a diminished social status for the service user (Williams & Keating, 2000). The power differentials inherent within NHS mental health services serve to perpetuate these inequalities, further hampering the experience of service users in psychiatric settings (Williams & Keating, 2000; Whitleock, 2009). Evidence suggests that mental health professionals are considerably indifferent to the impact of social inequalities on the lives and mental health of service users (Brown & Stein, 1997). This poses greater risk of inequalities being replicated within mental health services (Williams & Keating, 1999).

Indeed existing evidence reveals that some staff members believe that black service-users are more violent and aggressive than their white counterparts (Browne, 1995). A suggested consequence of this misconception is that higher numbers of incidents that are associated with the inappropriate use of medication and the misuse of physical restraint involve black service-users (Browne, 1995). One such incident resulted in the death of an African-Caribbean man, named David Bennett, who died following a prolonged period of time in the restraint position (Blofeld, Sallah, & Sashidharan, Stone, & Struthers, 2003). The subsequent inquiry into the death of David Bennett revealed

compelling evidence of institutional racism at the Norfolk & Suffolk NHS Foundation Trust (Blofeld et al, 2003).

Over the past decade the prevalence of sexual abuse of women, predominantly perpetrated by male staff and service users in mental health settings, has been well documented (Mind, 2004). Evidence suggests that women who have been victim to sexual abuse prior to using inpatient services are at greater risk of being sexually victimised (Gutheil, 1991). Nevertheless, recent studies report that many mental health trusts have only just begun to eliminate mixed sex wards, thereby reducing the risk of sexual victimisation among service-users (Felton, 2012; Bowers et al, 2014). Due to the ongoing reduction to health funding within our current fiscal climate (National Quality Board, 2013) this may be unsurprising; however this is also potentially indicative of the lesser priority given to creating environments that are safe within mental health services (Felton, 2012).

Some critics purport that psychiatry is a social institution that protects the interests of those already in privileged positions of power (Williams & Keating, 1999), resulting in service-users being typically powerless in relation to service providers (Williams & Keating, 2000). The medical label of mental illness gives further credence to a common disregard for the credibility of abuse allegations raised by service users (Galphin & Parker; 2007; Williams & Keating, 2000). Evidence suggests that staff may perceive

abuse allegations as symptoms of mental illness, or believe that the patient consented, was responsible, or provoked the incident (Williams, 1998; Williams & Keating, 2000). Consequently, abuse victims do not report abuse as they risk their claims *'being disregarded, disbelieved and trivialised'* (Whitelock, 2009, p.31). The adult safeguarding system itself may further marginalise service-users by declaring them vulnerable and in need of the protection that can be provided by a practitioner (Whitelock, 2009). Such positions of power are noted for their naturalistic orientation toward corruption within multiple societal contexts (Whitelock, 2009), and this is particularly evident within mental health.

Institutional Abuse and Staff Complacency

Despite being forbidden under Hippocratic Oath and professional codes of conduct (Mental Health Act, 1959; Williams & Keating, 2000), history is replete with references to the abuse of patients within therapeutic relationships and by healthcare professionals (Goodwin & Cramer, 2005)[7]. Existing literature identifies institutional abuse as a particular issue for adult safeguarding, which remains *'widespread and unchecked'* (Whitelock, 2009). In addition to some fundamental functions of mental health service provision that are considered abusive, such as compulsory detention and treatment, and locked door policies (Williams & Keating, 2000; van der Merwe et al, 2009); the inappropriate use of medication, the misuse of physical restraint, failure to respond to

[7] Please see the preceding discussion of historical institutional abuse p. 10-18.

abuse allegations, discrimination, aggression and bullying, and sexual and physical assault, are identified as contemporary issues within inpatient settings (Whitelock, 2009).

Indeed, the *Investigation into the Service for People with Learning Disabilities Provided by Sutton and Merton Primary Care Trust* revealed *'restraint was used inappropriately at times when it should have been used as a last resort'* (Healthcare Commission, 2007, p.3). One woman had been subjected to a form of restraint for many years where a splint was applied to her arm to restrict movement and prevent her from putting her hand in her mouth (Healthcare Commission, 2007). Similarly, a joint investigation into learning disability services at the *Cornwall Partnership NHS Trust* revealed that in many cases the trust followed the correct procedures for the protection of vulnerable adults; however, they also found that staff were unaware that certain practices e.g. the use of restraint, constituted abuse (Galphin & Parker, 2007). Incidents resulting in fatality within mental health settings include that of Azrar Ayub, who died in a secure mental health unit in Manchester after being sedated and physically restrained (The Mental Health Act Commission, 2009).

Evidence also highlights the complacency of ward staff to respond to instances of abuse in inpatient settings. Responses to a survey conducted by Mind (2009) revealed concerning levels of indifference among staff members to instances of abuse on

inpatient wards (Whitelock, 2009). The incidents disclosed within survey responses, included a patient with an unexplained broken arm and a service-user who was repeatedly punched in the face by another service-user, whilst staff members looked on (Whitelock, 2009). When questioned about these incidents, staff members declared that it was not possible to *'watch them all'* and that patients are responsible for defending themselves in certain situations (Whitelock, 2009, p.37). Responses from staff members regarding their non-compliance with adult safeguarding procedures in these instances revealed a commonly held belief that such occurrences 'come with the territory' (Whitelock, 2009). Johnson (2006) further points out that reporting only occurs if there are risks of litigation, *"staff members wish to point out to management areas of insufficient staff resources, or health and safety issues"*, or the incident is considered serious enough, which is determined by the level of harm to the patient (Johnson, 2006, p.36; NPSA, 2006).

Public Protection and the Criminal Justice System

A significant aim of policy development for the modernisation of mental health services has been the provision of safe services (DH, 1998). Due to a number of homicide cases involving people with mental health difficulties (e.g. Chris Clunis), the impetus for change has focused on the protection of the public and managing risk in the community (Boardman, 2005; Lawrence, 2003). Despite evidence that one in four people experience some kind of mental health problem (Smith, 2002), the public do not link severe mental illness and common mental health problems and consequently don't

empathise with this client group (Sayce, 2000). Public fear of mental illness is likely to further marginalise service-users and reinforce inappropriate responses to abuse by staff members who view psychiatric settings as a vestibule for public protection (Galphin & Parker, 2007). It is likely that staff members view their actions in response to service-users who are aggressive or abusive in nature, as justified and view incidents of abuse in this context, less seriously than if they occurred in the public arena (Galphin & Parker, 2007).

Professionals may use their discretion to deal with such incidents in-house, resulting in mere welfare-based responses to criminal acts that should be justifiably considered under the criminal justice system (Williams, 2002). The criminal justice system, however, is inherently problematic where the safeguarding of individuals with mental health problems is concerned (Whitelock, 2009). In particular, people living with mental health problems are reluctant to deal with the police regarding incidents of abuse, as they believe it will be assumed that they themselves are responsible for the abuse (Whitelock, 2009). Anecdotal evidence suggests that police officers associate mental illness with violence and are insensitive to the abuse of people living with mental health issues (Whitelock, 2009). In addition, people living with mental illness commonly report experiencing *'rude, patronising and dismissive behaviour'* at the hands of police officers (Whitelock, 2009, p.39). Attitudes such as these are suggested to contribute to queries relating to the credibility and reliability of reports of abuse by people living with mental illness, often resulting in the dismissal of legitimate cases (Whitelock, 2009).

Discussion

The aim of this preliminary literature review was to determine whether existing research offered insight into the dilatory approach to adult safeguarding adopted by NHS mental health services since the introduction of the No Secrets Guidance (DH, 2000). The results of a meta-search revealed that the literature sources available were predominantly commentary pieces, with a considerable lack of empirical focus on adult safeguarding in mental health. Nevertheless, examination of the literature available revealed a number of barriers to the establishment of effective practice for adult safeguarding in NHS mental health services. The findings suggested that there were significant difficulties associated with the translation of policy and legislation within the practice setting. These difficulties included: achieving a balance between individual rights and professional ethical duties; the effects of target focused management approaches on person-centred care; and a lack of recognition within national initiatives of the need for multi-agency adult safeguarding arrangements at an organisational level. It is recommended that customised guidance for mental health services is developed to enable the effective implementation of adult safeguarding policies and the establishment of transparent multi-agency partnerships within these organisations (Whitelock, 2009).

The findings also indicated that the existing link between social inequalities and mental illness is further perpetuated within mental health services. Social inequalities and powerlessness have devastating consequences for mental health service-users who are

at greater risk of having the credibility of their abuse allegations disregarded. In some cases, service-users have experienced further abuse at the hands of staff members within services (Williams and Keating, 2000; Whitelock, 2009). It is suggested that future approaches to adult safeguarding in mental health services include exploration of the social inequalities that dominate the lives of service-users as a central imperative (Williams & Keating, 1999; Williams & Keating, 2000). In addition, the implementation of personalised care plans that outline the steps to be taken when a person feels vulnerable and at risk of abuse is recommended (Whitelock, 2009; Williams & Keating, 1999; Williams & Keating, 2000).

The prevalence of institutional abuse was also highlighted within the review findings. In particular, the misuse of physical restraint, the inappropriate use of medication, inappropriate staff responses to abuse allegations, and the non-compliance of staff with adult safeguarding procedures, were identified as specific issues for mental health services. Despite the provision of extensive training in mental health services to prepare health professionals to deal effectively with service-users, they are failing to protect them from abuse and neglect (Williams & Keating, 2000). Indeed the findings suggested that in some cases staff members are unaware that certain accepted practices are abusive in nature (Whitelock, 2009). The stigmatisation of mental illness within society is likely to further exacerbate this issue due to societal expectation that national services will prioritise the protection of the public. This may inadvertently justify staff members

treating abuse allegations raised by mental health service-users, less seriously than if they had occurred within a public arena (Whitelock, 2009).

Conclusion

This preliminary review of literature revealed that NHS mental health services were disengaged from the wider adult safeguarding agenda and were failing to address the issue of abuse and neglect within their services. This problem is compounded by difficulties associated with translating policy into practice; the impact of social inequalities on the treatment of mental health service-users; the existence and acceptance of institutional abuse; and the stigmatisation of mental illness within society that serves to justify the inappropriate responses of staff members to abuse allegations raised by service users. Despite persistent acknowledgement of the need for a specific focus on this issue within existing literature, the review findings revealed that there had been little to no empirical work in this area.

A broader examination of safeguarding literature highlighted numerous strategies for the development of staff competencies within routine clinical practices associated with child protection. Empirical studies in this area focused on the development of competencies in areas such as problem-solving and analytical skills; judgement and decision making skills; and procedural practices for child protection (Appleton, 2009; Harbottle, 2007; Keys, 2009a; Keys, 2009b). Despite a clear requirement for a similar evidence-base for

adult safeguarding in the context of mental health, there is currently no information available regarding the development of practice in NHS mental health services (Williams & Keating, 1999; Whitelock, 2009).

The review findings led to the identification of two primary requirements for research development in the area of adult safeguarding in NHS mental health services. The first requirement was the need for establishment of the incidence and prevalence of abuse and neglect in NHS mental health services. It was determined that the establishment of incidence rates would reveal the scale of this problem for mental health service-users, which in turn would increase the priority given to addressing practice issues within services. However, due to the number of abuse incidents in NHS mental health services that are unreported, are not recognised as abuse, or are dealt with internally, it was concluded that to pursue this area would be a fruitless endeavour (NPSA, 2006; Mansell, 2009; DH, 2009).

The second research requirement identified was the need for empirical investigation of the implementation of adult safeguarding in NHS mental health services. More specifically, the findings suggested that there was a considerable gap in knowledge regarding the strategies used for implementation and the level of activity surrounding practice development in mental health. Indeed, criticisms of NHS mental health services suggest that they are unsatisfactory in their approach to implementing effective

practices for adult safeguarding (Brown & Keating, 1998; DH, 2009; Johnson, 2006). The present research therefore focused on making an empirical contribution to this body of knowledge. In order to identify the specific aims and objectives of the project a number of scoping activities were undertaken. These activities included informal discussions with practitioners in the field and a national survey of NHS mental health trusts. These activities are discussed in Chapter 2 and the aims and objectives of the research are outlined.

Chapter Two: Scoping Activities Outlined

Chapter Overview

For the purpose of illustrating the progressive development of this research, the following chapter will discuss a number of scoping activities that were used to identify the main aims and objectives of this project. The chapter begins with analysis of the informal discussions that took place between the researcher and four safeguarding practitioners regarding their views of adult safeguarding in their respective disciplines. A synopsis of the informal discussions that took place is presented, including discussion of: the structure of safeguarding teams; staff training and awareness; multi-agency partnership; barriers to practice; and suggestions for research development. The chapter continues by outlining the development and distribution of an online survey, followed by discussion of the survey findings. The chapter concludes with an outline of the main aims and objectives of the forthcoming qualitative phase, which were directly derived from the scoping activities undertaken.

2.1 Introduction

Scoping activities are used to "*identify a range and nature of existing evidence*" to aid the development of research questions and proposals (Davis et al, 2009, p.1386; EPPI-Centre, 2002; Levac, Colquhoun & O'Brien, 2010). Examples of scoping activities include early literature searches, initial interviews, and initial surveys (Davis et al, 2009). Scoping activities in the early stages of research can enrich a study and encourage an element of '*blue-sky thinking'* (Davis et al, 2009). During early supervisory meetings the findings of the preliminary literature review were discussed. In particular, attention was drawn to the absence of available information regarding the implementation of adult safeguarding in NHS mental health trusts at an organisational level. This was identified as an issue for the developing research project, hence the distribution of an online survey to gather the required information was proposed. In the first instance, the researcher was advised to informally engage with safeguarding practitioners to explore their views on early ideas about how to develop the project, as a way of scoping the perceived benefit of the proposed area of work. This would ensure the developing project was timely in terms of addressing current issues and transferable to practice settings. In addition, this activity would allow the researcher to explore whether an online survey would be of benefit to practitioners in the field.

2.2 Informal Discussions

During March and April 2010 the researcher met with four safeguarding practitioners based in NHS mental health trusts in the East and West Midlands regions. These individuals were identified by the academic supervision team, through phone calls to local organisations, and via word-of-mouth. A further conversation took place with one safeguarding practitioner in October 2010. Table 2.1 provides details about the roles and job titles of practitioners who engaged in informal discussions with the researcher during the preliminary stages of this research. Due to the informal nature of these discussions ethical clearance was not required; however permission was given verbally to use the information gathered to inform the development of an online survey. Detailed notes of participant responses[8] and retrospective memos were analysed and used to develop the synopsis of informal discussions that is presented below.

[8] Please see Appendix 2a for list of informal discussion questions

Table 2.1. Job titles and roles of safeguarding practitioners

Part No.	Organisation	Job Title	Safeguarding Role	Designation
1	NHS MH / LD Trust	Deputy Director of Nursing	Not designated (substantial involvement)	Strategic
2	NHS MH / LD Trust	Adult Safeguarding Lead Nurse	Safeguarding Lead Practitioner (mental capacity, deprivation of liberty, mental health act policy)	Operational
3	NHS MH / LD Trust	Adult Safeguarding Lead Nurse	Safeguarding Lead Practitioner (all areas of adult safeguarding)	Operational
4	County Council	Adult Safeguarding Development Manager	Lead for Adult Safeguarding within the Local Authority	Strategic

2.2.1 Synopsis of Informal Discussions

Structure of Safeguarding Teams

Discussions with safeguarding practitioners indicated that there was no standard organisational structure for safeguarding teams, such that some trusts had lead substantive posts for adult safeguarding with admin support while others were limited to named-nurse roles. The introduction of lead posts for adult safeguarding was considered a priority for those trusts currently limited to named-nurse roles to ensure that they were making progress *'in-line with other trusts'*. It was therefore proposed that a potential use of an online survey would include exploration of the organisational structure of adult safeguarding adopted by NHS mental health trusts nationally.

Staff Training and Awareness

Conversations with practitioners revealed that the use of strategies for the development of staff training and awareness for adult safeguarding was considerably varied among NHS mental health trusts. For example, one trust was heavily reliant upon the adult safeguarding element of mandatory training, whereas another trust actively promoted adult safeguarding via personal development reviews (PDR), clinical supervision and promotional material inserted into wage slips. It was generally felt that staff members had embraced adult safeguarding; albeit there were concerns that the introduction of a lead substantive post for adult safeguarding had caused some staff to take less initiative in terms of engagement. In particular, it was highlighted that some staff perceived the lead person as having ultimate responsibility for safeguarding thereby reducing the

need for their individual ownership. Operational managers were identified as a hard-to-reach group and in need of specific training for adult safeguarding. One practitioner suggested that mental health services need to be '*put under the spotlight'* and '*open to external scrutiny'* in a way that removes them from their protective culture. These revelations indicated that there were issues internally with the development of staff training and awareness that were not being addressed.

Multi-Agency Partnership

Some practitioners perceived multi-agency arrangements as sufficient and effective, while others identified them as ineffective. One practitioner suggested that high-profile safeguarding meetings were too big with little opportunity for safeguarding practitioners to discuss any specific issues in their area. Another practitioner suggested that multi-agency working is too generic and there is a clear requirement for customised training in the different areas of adult safeguarding. It was further highlighted that the responsibilities of mental health inpatient settings need to be clearly defined. Poor attendance at safeguarding conferences by NHS mental health services and the police force was identified as a particular issue for the development of multi-agency partnerships. These issues reveal a need to focus specifically on the improvement of inter-agency relations for adult safeguarding across and within national services to ensure that vulnerable groups are satisfactorily protected.

Barriers to Practice

Thresholds for adult safeguarding were identified as a barrier to practice in mental health and learning disability services. Practitioners suggested that thresholds in learning disability (LD) settings are too low in comparison with mental health (MH) services where thresholds are generally too high. Indeed one practitioner highlighted that most safeguarding cases occur within LD services, with considerably less adult safeguarding referrals in mental health services. However, there were mixed views with regard to how this should be interpreted. One practitioner suggested that the lower number of safeguarding cases in mental health services indicates that it is already firmly embedded within existing culture. In contrast another practitioner highlighted the fact that *'adult safeguarding is not embedded'* in mental health is the greatest barrier as there is a risk that it is being perceived as a specialist service. Additional barriers to effective practice included difficulties with establishing when a financial interaction between a vulnerable adult and another party is a safeguarding concern. More specifically, issues arise when a vulnerable adult has consented to a financial transaction and have thereby exercised their right to choice, despite evidence that they may have been taken advantage of. Adult safeguarding leads and managers have particular difficulty with best-interest decision making for vulnerable adults and experience a sense of isolation and lack of moral support when making difficult decisions.

Suggestions for Research Development

Practitioners supported the idea of distributing an on-line survey to gather factual information about safeguarding activity. A number of interesting areas for research development were proposed by practitioners, these are presented in Table 2.2. Practitioners highlighted a number of areas of interest with regard to strategic leadership and suggested that this information would provide an implicit indication of the level at which it is embedded within the organisation. Information regarding policy development was also considered of great interest, in particular whether a customised policy was in use and the impact of this on practice. Of further interest was the cost implications of safeguarding practice and the link between the cost of insurance premiums and the level at which policies are embedded. The content of nurse education and training courses was deemed important as this would determine whether future practitioners would be more attuned to the safety of service-users. Practitioners suggested that comparison groups in other disciplines e.g. primary care trusts (PCTs) and acute trusts, with regard to safeguarding activity would be useful, particularly where exemplary practice might be shared. Finally, practitioners highlighted the importance of capturing patient experience within the safeguarding process, and in particular the impact of forced procedures on the human rights and psychological well-being of service-users was also of interest.

Table 2.2. Areas for research development identified by SG practitioners

Research Area	Specifics

Strategic Leadership	• Are they a partner within their local safeguarding adults board (SAB)?
	• Is there an SAB representative?
	  o What band is he / she employed at?
	• Does a Trust Board Director have designated responsibility for adult safeguarding?
	  o What is his / her background / position?

Policy & Practice	• Is there a customised safeguarding adults' policy in addition to the multi-agency policy? • What impact have these had on staff? Have they improved practice and reduced risk?

Finance & Audit	• How do cost issues impact safeguarding practice?
	• The price of insurance premiums (NHSLA) is determined by the level at which adult safeguarding is embedded:
	  1. Policy exists
	  2. Policy is embedded
	  3. Practice is audited and monitored

Training & Education	• What are universities incorporating into their nurse training with regard to safeguarding?

Comparison Groups	• Primary Care Trusts (PCT)
	  o Traditionally had responsibility for adult safeguarding
	• Acute Trusts
	  o Picking up safeguarding by default and SA doesn't' seem to be a priority
	• Drug and Alcohol Services (I.D.A.S)
	  o How are children of drug and alcohol users protected? This is potentially a grey area.

Patient Experience	• Documenting the patient experience through the safeguarding process • Exploring the ways in which safeguarding interventions impact the psychological wellbeing of patients and contravene their human rights

2.3 Online Survey

2.3.1 Introduction

The areas proposed for research development by safeguarding practitioners were considered and a decision was made to focus the survey broadly on the organisational structure of adult safeguarding and the implementation and development of practice in mental health trusts. Due to the nature of the information required and the population under study the survey was cross-sectional and intended to represent adult safeguarding arrangements in NHS mental health trusts at the time of data collection. The survey was piloted by eight individuals employed within the local authority, an NHS trust and Staffordshire University. A number of amendments were made based upon the feedback and suggestions provided during the survey pilot. The survey received fast-track ethical approval from Staffordshire University[9] and was distributed in June 2010.

The objectives of the survey were:

1. To gather information about the organisational structure and the current level of adult safeguarding activity in NHS mental health trusts in England and Wales
2. To gather information about the establishment of monitoring procedures and multi-agency arrangements for adult safeguarding in NHS mental health trusts
3. To identify the main barriers to safeguarding adults with mental health difficulties and consider whether these differ to the challenges faced in other settings e.g. older adults, learning disabilities, and children's services

[9] Please see Appendix 2b for the approval document

2.3.2 Method

Procedure

A total of seventy-two (specialist mental health and combined) trusts that provide mental health services in England and seven health boards in Wales (n=79)[10] were identified and invited to participate via direct e-mail to their Chief Executive Officers (CEO)[11]. Initial e-mails included contact details of the researcher, background information of the study and an outline of the survey objectives with a survey preview link attached. In addition, CEOs were provided with a link to the full survey, which they were asked to forward to a person with leading strategic / operational responsibility for adult safeguarding. To maximise participation non-responders were sent regular reminder e-mails from June to September 2010. The survey was officially closed in September 2010.

[10]This was correct as of June 2010 and cross-checked against Binley's (2010) Directory of NHS Management

[11]Scottish mental health trusts were excluded from the study due to differences in adult safeguarding legislation

Materials

Qualtrics (2010) was used to design and build the survey. The survey questionnaire[12] was divided into five sections and used a variety of open-ended and closed questions, items with yes/no/other choices, and Likert items. The first section collected demographic information and provided details about participation, consent, and withdrawal. Informed consent was determined by an individual's willingness to provide contact details of the participating trust and proceed with completion of the survey. The second section enquired about different aspects of the organisational structure for adult safeguarding within trusts. This included substantive adult safeguarding posts; individuals with strategic responsibility; safeguarding teams; and details of all other safeguarding personnel. The third section sought information about the monitoring of adult safeguarding within trusts and in particular strategies used to raise awareness among staff and service-users and monitor day-to-day practices. Section four enquired about the personal views of practitioners with regard to the uptake of adult safeguarding within routine practice and triggers identified as having influenced improvement. Section five gathered information about multi-agency arrangements, specifically around the Safeguarding Adults Board representative and links between multi-agency and trust policies for safeguarding. The final section of the questionnaire enquired about the perceived differences between safeguarding arrangements for service-users in mental health settings in comparison with service-users in learning disability settings.

[12] Please see Appendix 2c for a sample of the survey questionnaire

Data Analysis

Descriptive statistics of quantifiable data were generated within Qualtrics. Qualitative responses provided within free text boxes were extracted and analysed manually using the principles of Thematic Analysis (TA) (Braun & Clarke, 2006). These were combined with quantitative data and are discussed conjointly within each individual section of the survey below.

2.3.3 Results[13]

Participants

Completed survey questionnaires were returned by thirty-two (97%) (specialist mental health and combined) trusts in England and one health board in Wales. The participating trusts were geographically dispersed, as shown in Table 2.3. and sufficiently varied in the range of services provided. Demographic information regarding the individuals completing the survey was not collected.

[13] The results in this section have been published and are reproduced here with the permission of the authors (Fanneran et al, 2013).

Table 2.3. Geographical locations of participating trusts

Geographical Location	Trusts (n)	Trusts %
North West	2	6
North East	1	3
Yorkshire and the Humber	3	9
West Midlands	5	15
East Midlands	3	9
East of England	2	6
London	5	15
South West	7	21.5
South East	4	12.5
Wales	1	3

Organisational Structure

Substantive Lead Posts

The characteristics of substantive lead posts for adult safeguarding are shown in Table 2.4. Twenty-seven (82%) trusts identified a substantive lead post for adult safeguarding. Twenty-four (88%) of these posts were full-time permanent positions at Band 8A or above. Seventeen (63%) were combined with safeguarding responsibilities for service-users in other contexts e.g. sexual safety, domestic abuse, and child protection. Fifteen (59%) posts had been in place for less than two years; eight (30%) for two-to-four years and four (15%) of the identified posts had been in place for four years or more. Seven (21%) trusts (five that did not identify a substantive lead post) were discussing future plans to introduce full-time substantive lead posts for adult safeguarding. All thirty-three (100%) trusts had an identified substantive lead post for child safeguarding.

Table 2.4. Characteristics of substantive adult safeguarding posts

Content	Trusts (n)	Trusts %
Lead Substantive Post for Adult Safeguarding		
Yes	27	84
Band		
7	3	12
8A	10	38
8B	10	38
8C	3	12
8D	1	4
Working Pattern		
Part-time (18.75 hrs per week)	1	4
Full-time (37.5 hrs per week)	24	89
Add on (to a full-time role)	2	7
Job Type		
Permanent	26	96
Temporary	1	4
Number of years active in role		
Up to 1 year	7	26
1 to 2 years	9	33
2 to 4 years	8	30
4 years or more	4	15
Other responsibilities *e.g. child protection*		
Yes	17	63
No	10	37

Safeguarding Team

Seventeen (52%) of the participating trusts identified additional members of the safeguarding team. Extended safeguarding teams included individuals working in administration, training, public protection, domestic abuse, forensic services and social care. Sixteen (48%) trusts did not have a safeguarding team and 11 (68%) indicated there were no future plans to employ additional staff. Several other staff groups were highlighted within free-text responses for their invaluable input to adult safeguarding practice within trusts. These included: the safeguarding adults groups (SAG); serious untoward incident (SUI) managers; complaint managers; and human resources and information governance staff. Collectively these staff groups contributed to: information sharing and advice giving, training, the management of safeguarding alerts, and the provision of investigatory support.

Leading Responsibility

Thirty-one (93%) trusts identified up to four individuals with leading responsibility for adult safeguarding within their service. Twenty-two (68%) of these indicated that the identified individuals were also responsible for the leadership of child protection. Table 2.5 shows the setting and level of employment of those identified. The table shows that individuals with leading responsibility were employed in Band 8B positions or above (n = 87). Twenty-six (30%) were employed within the division of nursing, 13 (15%) worked in

operations / services, and 10 (12%) were employed in social Care[14]. The remaining individuals (n = 38) were widely dispersed across a variety of disciplines. Some of the identified individuals held as little as 5% of the responsibilities associated with adult safeguarding leadership, while others were responsible for up to 90% of the associated tasks. Individuals employed within the nursing division were predominantly identified as operational leaders.

[14] These trusts had combined health and social care services

Table 2.5. Settings and employment level of leading strategic / operational roles for adult safeguarding

	Level of Employment (Band 8B+)						
Settings	Executive	Director	Deputy Director	Manager	Named / Consultant	Total (n)	Total %
Nursing		9	3	2	12	26	30
Operations / Services		10		3		13	15
Social Care		10				10	12
Safeguarding		1	2	6		9	11
Various			7			7	8
Quality & Performance		5	1			6	7
Integrated Teams				4		4	4
Mental Health			2	2		4	4
Patient Safety				3		3	3
Recovery & Rehabilitation			2			2	2
Chief Executive Officer	1					1	1
Clinical		1				1	1
Medical		1				1	1

Multi-agency Arrangements

Thirty-two (97%) trusts identified an Executive lead, e.g. Director of Nursing / Social Care who represented their trust on the local area 'Safeguarding Adults partnership'. One trust had designated this responsibility to the Named Nurse for adult safeguarding who reported directly to the trust's executive lead. Twenty-three (69%) trusts were producing an annual report on adult safeguarding practice: eleven (48%) of these had been producing this report for up to two years; seven (30%) were producing it for between two-to-four years and four (17%) trusts were producing the report for four years or more. Seven (21%) trusts who were not currently producing their own report indicated via free-text boxes that they were contributing to reports produced by local authorities, county councils, and local SABs. One trust had plans to commence the production of an annual report in 2010 / 2011.

Training, Awareness and Monitoring Practice

Thirty-one (93%) trusts were engaged in the provision of training to individuals employed between Bands 1 through 8a. In addition, 27 (81%) trusts were providing training to individuals employed at Bands 8b and 8c, 25 (75%) were providing specialist training to those working at Band 8d, and 24 (72%) were providing training to those employed at Band 9. Free-text responses revealed that some trusts were engaged in additional activities to promote awareness among staff members. This included six (18%) trusts that were using lunchtime seminars, 23 (69%) were circulating promotional literature and a further 23 (69%) identified 'other forums', which included a dedicated intranet site, staff roadshows, team meetings, trust

newsround, induction, e-learning modules, and supervision. The distribution of promotional literature (69%), the use of one-to-one consultations (54%) and word-of-mouth (51%) were also methods used by trusts to generate adult safeguarding awareness among service-users.

Free-text responses revealed that additional interventions such as roadshows, local events, formal training, the Internet, intranet, conferences, workshops and presentations were used to generate awareness. The provision of 24-hour access to adult safeguarding information via Internet and intranet pages to staff and service-users was also highlighted as particularly important. Free-text responses also emphasised the use of websites and e-learning tools during training to illustrate the complexity of the issues that may be faced in practice. Staff practices were monitored via clinical supervision (90%), staff appraisals (63%), and during team meetings (69%). Alternative means for monitoring staff practices included: the incident reporting system, case file / clinical audits, safeguarding adults meetings, serious case reviews, peer-supervision groups, complaints, and investigations. Additionally, 21 (63%) trusts utilised a computerised reporting system to collect and monitor information around protection issues.

Barriers and Facilitators of Best Practice

Free-text responses revealed that multi-agency working was considered crucial to effective practice; albeit there were concerns about the lack of statutory requirements for adult safeguarding. Respondents suggested that although adult

safeguarding is generally embraced at an organisational level barriers are evident; staff attitudes, responses and behaviour were central to those identified. Indeed, it was suggested that front-line staff do not readily accept responsibility for adult safeguarding and do not consider it obligatory. In particular, staff members tend to rely upon familiar processes such as The Care Programme Approach (DH, 1990) despite the appropriateness of using adult safeguarding in many cases.

There were specific concerns about demonstrating the applicability of adult safeguarding to staff members across the wide variety of settings, duties and types of illness that exist in mental health services. The *No Secrets* (2000) guidance was most commonly identified as having triggered enhanced awareness of the need for adult safeguarding within services (DH, 2000). This was followed by learning from Serious Untoward Incidents (SUI) and Care Quality Commission (CQC) inspections. Free-text responses revealed that the attitudes of 'old school staff' who adopt a traditional approach to the delivery of care were a concern for some trusts, in particular their responses to investigations by external agencies were identified as an issue. Despite this, public inquiries and investigations were deemed to stimulate thought and awareness among staff about the consequences of failing to respond when things go wrong. It was suggested that there is an immediate need to prioritise safeguarding training for staff members with an equivalent expectation of attendance as mandatory training requires.

Perceived Differences between Health Settings

Responses suggested that adult safeguarding is equally applied across all settings; however there are differences between the challenges faced among service-user groups. Issues of capacity, although contrasting, were highlighted for both mental health and learning disability service-user groups. Indeed, mental health service-users experience fluctuating states of capacity and may be wrongly assumed to have capacity, whereas adults with learning disabilities may be wrongly assumed to lack capacity. In addition, the prevalence of vulnerability among learning disability service-users results in higher numbers of adult safeguarding referrals in these settings. Due to the increased exposure of staff members to adult safeguarding processes, the standards of practice and performance are noticeably higher in learning disability settings and staff members appear to be more cautious.

2.3.4 Discussion

The aim of this on-line survey was to investigate the organisational structure, and implementation and development of adult safeguarding in NHS mental health trusts in England and Wales. The 41% response rate achieved provides a reasonable snap-shot of the use and development of adult safeguarding in NHS mental health trusts at the time of distribution. The findings suggested that the leadership arrangements for adult safeguarding in NHS mental health trusts were adequate, with 82% of participating trusts identifying a substantive lead post and 97% identifying a strategic lead at executive board level. Despite this, a minority (16%) had yet to implement a lead post for adult safeguarding and 59% of those posts

identified were operational for less than two years. In addition, one trust had assigned strategic responsibility to a named nurse and just one trust in the sample identified the CEO as the strategic lead for adult safeguarding.

These findings differ greatly to the development of adult safeguarding in other healthcare settings and are non-compliant with recommendations for the establishment of effective practice. For example, the implementation of lead posts for adult safeguarding in acute and primary care trusts has been ongoing since 2004 (Draper et al, 2009). Furthermore, the 'Consultation on the Review of the No Secrets Guidance' (DH, 2009) highlights the importance of appropriate representation on the local Safeguarding Adults Board for the development of effective multi-agency practice, and the ability of some partner agencies to continually impede this process (AEA, 2006).

The survey results suggest that the provision of adult safeguarding training in NHS mental health trusts is good with the majority of responders (93%) indicating that clinical staff between Bands 1 through 8a receive training. The use of pro-active strategies was also evident with a number of innovative approaches highlighted. However, issues associated with staff attitudes and the integration of adult safeguarding processes within routine practice were a concern for some trusts. This is consistent with existing research which highlights the impact of issues such as these on the level at which adult safeguarding is embedded within an organisation's infrastructure (Brown & Keating, 1998; NPSA, 2006; DH, 2009; DH, 2011). Survey

responses suggest that the standard of practice in learning disability settings is higher due to the increased exposure of staff to safeguarding issues within this environment. It is possible that the increased demand for safeguarding interventions in learning disability settings exhausts all available resources, limiting the time available to address issues in mental health settings.

As this survey was the first of its kind there was a lack of available data with which to compare responses or response rates. The information gathered sufficiently provided insight into adult safeguarding use in NHS mental health services; however due to the predominant use of frequency data and descriptive information the findings were preliminary. There were also a number of potential limitations associated with the survey methodology. In particular, the depth and richness of the data gathered may be limited by the use of a-priori questions. Furthermore, surveys incur a risk of self-report bias with a possibility of participants answering favourably to portray a positive image of adult safeguarding practice within their services. However, the findings revealed both positive and negative insights into adult safeguarding practice in mental health, which minimises this risk.

Conclusion

The survey results suggest that at the time of distribution adult safeguarding in NHS mental health trusts was in its initial phase of implementation (Fanneran et al, 2013). In particular, the results indicated that some trusts were following protocol with regard to adult safeguarding; however the level of commitment was varied across services. It was evident that some trusts were taking a more proactive approach to safeguarding adults than others and barriers existed at both strategic and operational levels that required immediate attention.

2.4 Study Progression

The information gathered during the survey was invaluable to this research. It provided an outline of the organisational structure of adult safeguarding in 33 NHS mental health trusts, identified important areas for future exploration and adult safeguarding policies for those trusts that participated were collated. Additionally, 22 safeguarding lead practitioners indicated their willingness to be contacted by the researcher for future research participation. Some free-text responses provided insightful information regarding barriers to practice and factors associated with the successful implementation of adult safeguarding in NHS mental health services[15]. For example, issues concerning the engagement of staff across the wide variety of settings that exist in mental health were highlighted. Due to the limited ability to explore issues such as these when using a survey methodology a decision was made to adopt a qualitative approach within the next phase of study. The main aims and objectives of this research are outlined in the next section.

[15] These can be seen in Appendix 4a.

2.4.1 Aims and Objectives

The following are the aims and objectives of this research, which were derived directly from the scoping activities discussed in the preceding chapters.

Research main aims**:**

A. To explore the implementation, development, and use of adult safeguarding practices and procedures in NHS mental health services
B. To improve understanding of the structures and processes involved in keeping adults safe in mental healthcare and identify whether the challenges faced differ to those in other settings

Research objectives**:**

1. To explore and critically analyse stakeholders experiences and perspectives of implementing adult safeguarding practices, procedures and policies and their use in NHS mental health trusts
2. To identify, explore and critically analyse stakeholders experiences and perspectives of the main barriers to developing adult safeguarding practice in NHS mental health trusts
3. To identify, explore and critically analyse the specific circumstances under which adults with mental health difficulties are safeguarded from the perspectives of those involved
4. To critically review literature relevant to the implementation or development of adult safeguarding practice across NHS health services

Chapter Three: Research Philosophy

Chapter Overview

The following chapter establishes the philosophical orientation of the qualitative phase of this research. The chapter begins with an assessment of five main qualitative research traditions undertaken to identify the most appropriate qualitative approach for the current study. In particular, this chapter will consider the suitability of narrative, phenomenology, ethnography, case study and grounded theory approaches to the research aims and objectives. This is followed by exploration of the philosophical foundations of research and establishment of the constructivist orientation of the qualitative study.

3.1 Introduction

During the preliminary phase of the current study three scoping activities were undertaken to aid the identification of appropriate research questions. The activities undertaken included: a preliminary literature review (see Chapter 1); informal discussions with four safeguarding practitioners (see Chapter 3); and a national survey (see Chapter 3). Collectively, the findings of these activities highlighted the need for a qualitative approach during the empirical phase of this research. In particular, the preliminary literature search revealed a lack of empirical work in the area of adult safeguarding in mental health and the consistent use of qualitative methods in health studies due to their suitability to studying phenomena in applied contexts (Coates, 2004).

The data gathered during informal discussions with safeguarding practitioners and the online survey further indicated the need for a qualitative approach during the empirical study phase. For example, open-ended survey responses revealed that there were difficulties engaging front-line staff to take ownership for adult safeguarding, which was identified as a barrier to effective practice. In addition, responses revealed that practitioners believed there were considerable differences between adult safeguarding in mental health and learning disability settings. However, it was not possible to explore these issues further when using a structured survey methodology suggesting a qualitative approach would be more suitable for the subsequent phase.

Independent study of research methodologies further highlights the particular suitability of a qualitative approach to the present study. Qualitative methods are employed when the interpretation of human experience is necessary to enhance the understanding of social situations or answer micro sociological questions (Powers & Knapp, 1990; Cicourel, 1981). This is relevant to the present research due to accumulated learning from the early scoping activities indicating a need for analysis of adult safeguarding from an individual (micro) and organisational (meso) perspective to understand the use of national initiatives and guidance (macro) within practice settings. The pursuit of a qualitative inquiry would facilitate a focus on the every-day life and events that surround adult safeguarding practice (Coates, 2004).

3.2 Selecting a Qualitative Approach

An examination of the methodological and theoretical assumptions, and methods, associated with a range of qualitative approaches was undertaken to identify an appropriate research strategy for the next stage of the present study (Flick, 2009; Charmaz, 2006). The *Five-Question Method for Framing a Qualitative Research Study*[16] (McCaslin & Wilson-Scott, 2003) was used to aid this process. This method proposes the use of five-questions (see Table 1) to help identify the most appropriate of five qualitative research traditions in order to frame a research study i.e. Narrative Research, Phenomenology, Grounded Theory (GT), Ethnography and Case Study (McCaslin & Wilson-Scott, 2003; Cresswell & Poth, 2017). The questions encourage the novice researcher to focus on *'what it is they are trying to discover'* emphasizing

[16] The Five-Question Method for Framing a Qualitative Research Study (McCaslin & Wilson-Scott, 2003) can be seen in Appendix 3a

'that it is possible to answer multiple questions with different perspectives of a single topic of interest' (McCaslin & Wilson-Scott, 2003, p.450).

3.2.1 Narrative Research

Narrative research embodies a range of research strategies that utilise 'stories' told by individuals along with other personal materials (e.g. sentimental objects) to better understand them within their social context (Flick, 2009; Roberts, 2002, p.12). Researchers working within this tradition use the terms, *biography*, *autobiography* and *narrative,* synonymously and the inclusion of a broad range of textual materials is common (Roberts, 2002; Huber, 2017). Such materials may include narrative interviews, auto/biographical texts, family stories, letters, diaries, annals, chronicles, conversations and field notes (Roberts, 2002).

The predominant focus of narrative approaches is to explore individual accounts of life experience (Flick, 2009; Cresswell & Poth, 2017). Narrative approaches may include interview data; however they are not limited to formal interviewing methods, which facilitates the exploration of individual experiences more freely (Flick, 2009; Creswell & Poth, 2017). Consequently, narrative approaches are heavily criticised for their lack of rigour and consistency in applying methodological and analytical frameworks (Huber, 2017). Due to a preference for a methodical approach to data collection and analysis and the lesser importance of conceptualising the individual's reality and identity within the present study, a narrative approach was deemed unsuitable.

3.2.2 Phenomenology

In contrast with narrative approaches, phenomenological research seeks to convey the shared experiences of a group of individuals regarding a particular concept (Creswell & Poth, 2017). The specific focus of a phenomenological approach is to identify what is common among participant experiences to reach a universal description of the phenomenon itself (van Manen, 2014). In order to describe the phenomenon as experienced by all individuals, one must essentially capture the essence of *'what they experienced and how they experienced it'* (Moustakas, 1994, p.27). The distinctive features of a phenomenological approach include: exploration of a single idea or concept with a heterogeneous group of individuals; rejection of a subjective / objective divide substituted by acceptance of a unified continuum between quantitative and qualitative research; a clear distinction between the researchers own experiences of the phenomenon and those of participants (bracketing); and development of textual and structural descriptions to produce a composite description that represents the essence of the phenomenon.

The relevance of capturing the essence of shared participant experiences with regard to adult safeguarding was recognised; however, due to the absence of a single identified concept and the varied nature of adult safeguarding provision within mental health services, a purist phenomenological approach was also discounted during this initial assessment.

3.2.3 Ethnography

Ethnography was the third approach explored for its suitability to the present study. Ethnographic approaches *'describe and interpret the shared and learned patterns of values, behaviours, beliefs and language'* of individuals within the same cultural group (Harris, 1968, p.17). To this end study participants are usually located in the same place or interact frequently enough to allow them to develop shared patterns of behaviour and language. The aim of an ethnographer is to become immersed in the daily lives of a cultural group to study the meaning of their shared interactions, behaviour and language. This is achieved through multiple methods, which may include: the researcher's field notes (observations, spontaneous conversations, remarks overheard), interviews, written documentation, audio / video recordings, and quantitative data where appropriate (Creswell & Poth, 2017).

Despite the researcher's interest in Ethnography, the focus of the present study was not the shared commonalities of a cultural group. Individuals with responsibility for implementing adult safeguarding in NHS mental health trusts share similar experiences; however they would be employed within different organisations and would not necessarily belong to the same cultural group. The possibility of treating individual trusts as distinctly separate cultural groups was considered, but reflections on discussions with safeguarding practitioners led to this also being discounted. Conversations with practitioners suggested that while individuals with responsibility for adult safeguarding share a common interest, these responsibilities are very often incorporated within existing roles. There is, therefore, little in the way of a shared culture for adult safeguarding between individuals working within mental health

trusts. In addition, the logistics of being immersed within several cultural groups was deemed impractical and unsuitable by the supervisory team.

3.2.4 Case Study

Case study methodology was the next approach explored for its suitability to this research. Case study approaches are used to empirically investigate phenomena within their real-life context when *'the boundaries between phenomenon and context are not clearly evident'* (Yin, 1984, p.23). Case studies incorporate multiple sources of evidence and attempt to illuminate *'a decision or set of decisions: why they were taken, how they were implemented and with what result'* (Schramm, 1971, p.1; Yin, 2009). The case under study can take several forms including: an individual, an organisation, an institution, a process, a neighbourhood, or an event (Yin, 2009).

Case study research is often criticised for a lack of systematic procedures and uniformity where quality is concerned (Yin, 2009). The relevance of exploring a phenomenon within its naturally occurring context and the inextricable link between the two was recognised; however, the time-consuming nature of conducting a series of case studies and amassing large amounts of potentially unusable data caused uncertainty about selecting this approach. Consequently, a final decision about whether or not to use this methodology was delayed until all potential methodological approaches had been considered.

3.2.5 Grounded Theory

Grounded Theory (GT) was the final approach considered for the present research (Glaser & Strauss, 1967). GT was first proposed by Glaser & Strauss (1967) as *"a general method of analysis"* that could incorporate *'qualitative, quantitative, and hybrid data'* (Glaser, 1978, p.83) to develop *'a unified theoretical explanation'* of a process or action (Corbin & Strauss, 2007, p.107). Somewhat similar to ethnography a GT approach is contingent upon all participants having experience of the process under study. GT, however, moves beyond description to the development of theory that is grounded in the actions, interactions and social processes uncovered within the data collected (Creswell & Poth, 2017). The resulting theory is substantive, absent of preconceived notions and focuses on a specific empirical area (Glaser & Strauss, 1967). Substantive theory may be further examined within multiple contexts to determine relatedness to formal / grand theories (Glaser & Strauss, 1967).

During this initial assessment of qualitative approaches GT was perceived as the most suited to the present study. In the absence of existing empirical studies that explore the use and development of adult safeguarding in mental health services, a GT approach would contribute a context specific theory. Purposive sampling methods would allow for the selection of appropriate participants to explore the issues raised within the qualitative feedback received from survey respondents. In addition, the systematic method of data collection and analysis within a grounded theory approach embraces the concept of comparison cases (Glaser & Strauss, 1967), such that NHS trusts could be classified as individual entities. This would

alleviate any potential criticisms regarding the lack of uniformity suggested of other qualitative research approaches (Cresswell & Poth, 2017).

Initial readings of the GT literature revealed a number of contentions regarding early ideas proposed by Glaser & Strauss (1967). In particular, the positivistic assumptions of the original GT approach were heavily criticised due to wide recognition that the art of interpretation is undoubtedly subjective in nature (Bryant & Charmaz, 2007). Strauss & Corbin (1990) addressed some of these criticisms within their alternate GT approach. They suggested that a researcher's unbiased position could be maintained by utilising methodical coding strategies and the constant comparative method, which is a process of simultaneous data coding and analysis (Glaser & Strauss, 1967; Strauss & Corbin, 1990; Charmaz, 2006; Moghaddam, 2006). This would serve to re-establish the reliability of GT as a useful method for conducting qualitative research studies.

Advancements in the critical discussions surrounding GT practices highlight the existence of two distinct approaches: constructivist grounded theory versus objectivist grounded theory (Charmaz, 2000; 2001). These opposing camps reflect early divergences in the development of GT that are predominantly associated with the positioning of the researcher within the research process. Indeed, contemporary proponents purport that GT can be used as a flexible set of guidelines adapted to the needs of a research topic with the possibility of multiple theoretical and philosophical influences, usually imposed by the researcher (Charmaz, 2006). It was therefore

necessary to consider the theoretical and philosophical assumptions that underpin research to determine which GT approach would be used in the present study.

3.3 Research Philosophy

In order to understand the philosophical assumptions that underpin research, the first essential step is to consider the *'nature of knowledge'* that will be produced, *'its possibility, scope and general basis'* (Hamlyn, 1995, p.242; Bryant and Charmaz, 2007). Of further consideration are the assumptions made when undertaking research regarding, *'the nature of existence and the structure of reality'* and how this impacts the stated outcomes of a study (Crotty, 1998, p.10). Together these considerations establish the philosophical positioning of a research study and help to determine its utility within a wider theoretical context.

A paradigm is commonly referred to as a 'worldview' that describes *'the nature of the world, the individual's place in it, and the range of possible relationships to that world and its parts'* (Guba & Lincoln 1994, p.107). The term paradigm denotes the comprehensive set of ideas, concepts and thought patterns about how something works; hence it is adapted and used in a variety of ways (Johnson, McGowan & Turner, 2010). For example, when applied to research, a paradigm may specifically refer to the theoretical frame that embodies a research study, which may subsume either qualitative or quantitative methods (Lincoln, Lynham & Guba, 2011). Alternatively, the term can be used in a broader sense to differentiate between qualitative and quantitative approaches (Howitt & Cramer, 2005).

In the present study, the term paradigm refers specifically to the comprehensive framework of philosophical beliefs, values and assumptions that guide the researcher through the process of research. A paradigm is comprised of four philosophical dimensions, these are: *epistemology, ontology, axiology and methodology*. Epistemology is concerned with *'the nature of knowledge, its possibility, scope and general basis'* (Hamlyn, 1995, p.242). Epistemological assumptions regarding *'the relationship between what we know and what we see'* and *'the truths we seek and believe'* are fundamental to understanding the knowledge gleaned through research (Lincoln, Lynham & Guba, 2011, p.103; Crotty, 1998; Bernal, 2002; Guba & Lincoln, 2005; Lynham & Webb-Johnson, 2008).

Ontology is the study of being in the world and is concerned with the structure of existence and the nature of reality (Cresswell, 2007; Crotty, 1998). Axiology deals with ethics, aesthetics and religion and considers value assumptions made within the process of human inquiry (Lincoln, Lynham & Guba, 2011). In particular, it addresses the influence of values and ethics on the choices made throughout the research process (Data, 1994; Crotty, 1998). Methodology deals with *'the process of how we seek our new knowledge'* and the most appropriate means or strategy for acquiring this knowledge (Guba & Lincoln, 1994; Schwandt, 2007, p.190; Cresswell, 2007). Together, these dimensions form the basic belief system of human inquiry and are the essence of knowledge acquisition and development (Lincoln, Lynham & Guba, 2011; Cresswell, 2007).

Table 3.1 outlines the differing philosophical assumptions made within five research paradigms that have dominated the social sciences (Denzin & Lincoln, 2011), namely: *positivism, post-positivism, critical (theories), constructivism, and participatory*. The table shows that the ontological premise of positivism is rooted in *naïve realism,* which asserts the presence of a tangible and true reality that can be measured (Lincoln, Lynham & Guba, 2011). Within this paradigm the aim of research is to predict and control nature (Guba & Lincoln, 2005). Contrastingly, the ontological assumptions of constructivism are firmly *relativist* in nature and postulate the existence of multiple-constructed realities that are specific to the individual (Howitt & Cramer, 2005; Onwuegbuzie & Leech, 2005; Tashakkori & Teddlie, 1998). The constructivist perspective assumes there is no absolute truth or validity; rather the aim of research is to produce knowledge that reflects the *'lived experience'* and individual social interactions (Guba, 1996; Guba & Lincoln, 2005; Lincoln, Lynham & Guba, 2011).

Table 3.1. A table to illustrate the philosophical elements of five competing research paradigms

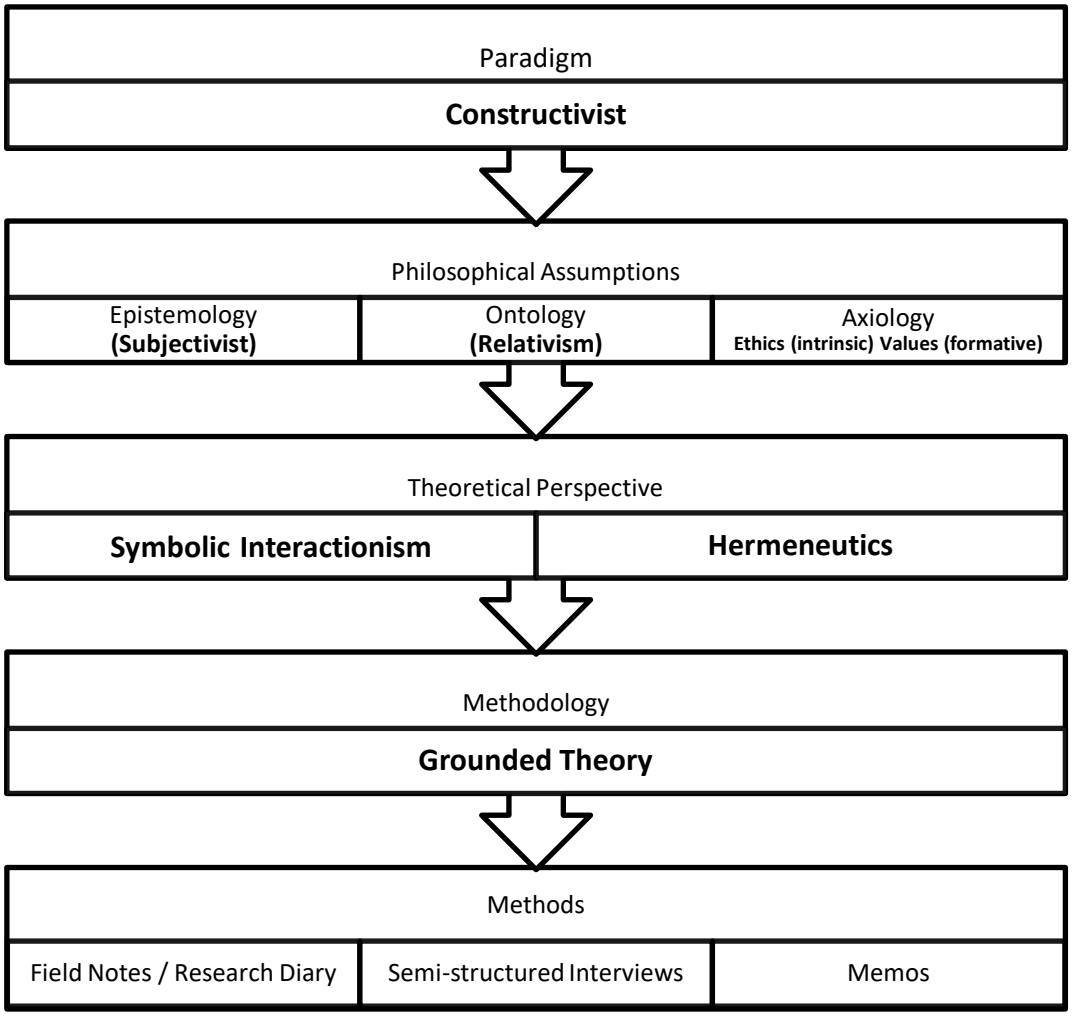
Philosophical Element		Positivism	Post-positivism	Critical Theories (Feminism / Racism)	Constructivism	Participatory
Ontology		Naive realism – "real" reality perceived directly by participants	Critical realism – partial "real" reality but acknowledges inaccuracies	Struggle for power - leads to interactions of privilege and oppression	Relativism – multiple constructed realities with no absolute truth	Participative reality is always subjective-objective shaped by participants
Epistemology		Objectivist – findings are true	Objectivist – findings are approximated	Knowledge can change existing oppressive structures and remove them through empowerment	Subjectivist – findings are the creation of the process of interaction between inquirer and inquired	Critical subjectivity – findings are co-created
Axiology	Ethics	Extrinsic – tilt towards deception	Extrinsic – tilt towards deception	Intrinsic – moral tilt toward revelation	Intrinsic – process tilt toward revelation	Intrinsic – moral tilt toward revelation
	Values	Excluded – influence denied	Excluded – influence denied	Included - formative	Included – formative	Included – formative
Methodology		Deductive – experimental; verification of hypotheses; predominantly quantitative methods	Deductive – experimental; falsification of hypotheses; may include qualitative methods	Dialectic – participatory research empowers the oppressed and supports social transformation	Dialectic – individual constructions are elicited, refined, compared and contrasted. Aim to generate constructions on which there is consensus.	Collaborative participation of all involved at all stages of research

Adapted from Denzin & Lincoln (2011); Cresswell & Plano Clark, (2011)

Table 3.1 also provides a description of the methodology associated with each paradigm. The methodology adopted within each paradigm is directly related to its epistemological, ontological and axiological assumptions. For example, research that is aligned within a critical paradigm maintains an ontological worldview of human existence through a struggle for power and oppression. The epistemological belief that knowledge is produced through the study of social structures, freedom and oppression, and power and control, lends itself to the dialectic approach adopted within a critical paradigm (Merriam, 1984; Bernal, 2002). In particular, as these are not measurable tangible concepts a dialectic approach facilitates the paradigms inquiry aim, which is to stimulate those who are oppressed to rationally scrutinise their lives (Fay, 1987).

This brief discussion of the foundations of research approaches highlights the importance of the interrelated philosophical concepts: epistemology, ontology, axiology and methodology during the development of a research study. Figure 3.1 provides a top-down illustration of the paradigmatic framework of the present research. It identifies the present study as constructivist in orientation with subjectivist epistemological and relativist ontological assumptions. Ethics are intrinsic within this paradigm and values are considered personally relative and formative (Guba & Lincoln, 2005). The present study is theoretically influenced by symbolic interactionism / hermeneutics and adopts a *grounded theory* methodological approach. In the next section each philosophical component will be discussed in detail in order of how it is presented in Figure 3.1.

[17]Figure 3.1. A figure to illustrate the paradigmatic framework of the present research



[17] Please see Appendix 3b for a list of figures

3.3.1 Paradigmatic Framework

During the process of establishing the paradigmatic orientation of the present study, several world-views were considered in relation to their compatibility with the needs of this research. Positivism, which relies upon the application of the scientific method, was explored for its relevance; however it was quickly discounted. Positivist approaches attempt to establish cause-and-effect relationships within controlled environments in order to develop concrete laws over time (Guba & Lincoln, 2005). The findings of early scoping activities clearly indicated the specific need to qualitatively explore several emergent issues regarding adult safeguarding. For example, responses revealed that staff attitudes and responses to investigations were a barrier to effective practice. Attempts to maintain a purely positivist worldview when exploring individual experiences of adult safeguarding would be folly as the subjectivity of findings must be acknowledged, hence an absolute truth is unattainable.

Post-positivism, a close cousin of positivism similarly aims to attain reality, albeit an approximate one (Merriam et al, 2007). The aim of post-positivist research is to achieve a statistically accurate interpretation of reality (Guba & Lincoln, 2005). Post-positivism was also considered in relation to the requirements of this study. Indeed, a considerable amount of time was spent exploring the possibility of designing a quantitative study to investigate the engagement of NHS mental health services with the national adult safeguarding agenda. However, due to the absence of accurate benchmarks with which to measure this and the survey findings suggesting that outwardly the majority of trusts were compliant with national requirements (see

Chapter 2), this was not possible. In addition, revelations within open-ended survey responses highlighted that the compliance of NHS mental health trusts was potentially superficial as considerable barriers were evident that were not being addressed. It was therefore determined that qualitative data would provide a more meaningful insight into factors that facilitate effective practice for adult safeguarding in mental health services and those that act as a barrier.

Critical theories and *participatory* approaches were also considered for their applicability to the present study. The aim of a critical inquiry is to *'stimulate oppressed people to rationally scrutinize their lives'* in order to understand the truth as it relates to social power struggles and stimulate change (Lincoln, Lynham & Guba, 2011, p.110). Oppressed subjects are central to research carried out in this paradigm, as is the promotion of rationality as a means to better knowledge (Fay, 1987; Kilgore, 2001). While, individuals who are the victim of abuse and neglect might well be viewed as oppressed, they are not the direct focus of this study; a critical approach was therefore discounted. A participatory worldview asserts that knowledge is socially constructed and that *'knowers can only be knowers, when known by other knowers'* (Heron & Reason, 1997, p.280). Research carried out within this paradigm stipulates that researchers and participants must be co-researchers, and the researcher must be an active participant in the topic under study (Guba & Lincoln, 2005). However, in the current study the researcher was not involved with the delivery of adult safeguarding and thus maintained an *etic* perspective. A participatory approach was therefore also ruled out.

Research that is conducted within a constructivist paradigm assumes that '*the constructed meanings of actors are the foundation of knowledge'* (Guba & Lincoln, 2005, p.196). The aim of inquiry within a constructivist paradigm is *'to understand and interpret the meaning of phenomena obtained through the joint construction and reconstruction of individual lived experience'* (Lincoln, Lynham & Guba, 2011, p. 107). In addition, constructivism objects the notion that all problems may be understood in terms of scientific generalisations (Guba & Lincoln, 1994). Indeed, it is suggested that all qualitative approaches are somewhat constructivist in nature (Charmaz, 2006). The constructivist paradigm was identified as the most applicable to the present research. In particular the researcher acknowledges her role as co-constructor of this research, through the undertaking of early scoping activities and through the understanding and interpretation of the meaning of individual and collective *'lived experiences'* in research interviews (Guba & Lincoln, 2005).

Theoretical Perspective

The theoretical perspective associated with a research paradigm provides further context for the process of research and informs its associated methodology (Crotty, 1998). The theories that most commonly underlie interpretivist forms of research are phenomenology, symbolic interactionism and hermeneutics. Phenomenology is concerned with understanding how we directly experience objects or 'things themselves', before interpreting or attributing meaning to them (Crotty, 1996; Willis, 2001, p.2). A phenomenological endeavour asks that we *'recover a fresh perception of existence'* by setting aside our received notions so that we may *'create culture anew'* (Merleau-Ponty, 1964, p.181; Sadler, 1969, p.377). Phenomenology is thus

rooted in a suspicion of culture as inherently limiting despite being an intricate part of human existence (Armstrong, 1976). The present study does not comply with such ideals, due to acknowledgement of the influence of both the researcher's knowledge and presuppositions on the data. In addition, in the context of the present study, the researcher asserts that any attempt to develop understanding of the use of adult safeguarding must involve consideration of the culture within which it is embedded (Crotty, 1998).

Symbolic Interactionism assumes that human action in the world is based upon the meanings humans attribute to the world which are derived directly from social interactions with others (Blumer, 1969). From a symbolic interactionist perspective a situation must be understood in terms of how the *'actor sees it'* such that the actor's *'meanings of objects and acts'* are determined in order to see the social world through his eyes (Psathas, 1973, p.6 – 7). The researcher must therefore attempt to take the standpoint of those they are studying in order to interpret their meanings and intent (Crotty, 1998). The present research incorporates symbolic interactionist ideals within its research methodology. More specifically during the collection and analysis of data the importance of seeing the social world through the eyes of participants was considered a priority. In particular, the coding strategies associated with the grounded-theory method adopted in this study, ensures a level of transparency, whilst the methodology itself acknowledges the influence of the researcher and research participants on the entire process.

Hermeneutics in its historical form refers to the collection of theories, rules, principles and methods used to interpret biblical and philosophical texts (Crotty, 1998). Contemporary theorists define hermeneutics as '*the theory of the operations of understanding in their relation to the interpretation of texts*' and posit its application to all human documents, activities and modes of communication (Ricoeur, 1992, p.143; Mootz & Taylor, 2011). The aim of the hermeneutical endeavour in contemporary research is to understand the lifeworld of participants (Mootz & Taylor, 2011). In particular, it views the participant as the only expert in his individual world of intersubjective meanings and constructions, and aims to develop an understanding of this world through narrative discussions with participants (Berger and Luckmann, 1966). It is suggested that all qualitative research is to some extent methodically hermeneutical (Rennie, 2012). The present study is also influenced by hermeneutics as it acknowledges the individual as the expert in his own lifeworld.

Conclusion

As discussed in this chapter, this study is constructivist in orientation and aims to acquire knowledge by way of interpreting the meaning and understanding of participant experiences. The worldview (ontology) posits that knowledge is constructed through an individual's lived experience and his / her social and contextual interactions. The epistemological assumptions oppose the concept of a universal reality; rather individual constructions of reality are evident and embedded within the individual's personal context and / or setting (Lincoln & Guba, 1985). Personal values and ethics are viewed as inherent to the research process and have been considered throughout all aspects of the inquiry (Geertz, 1973; Guba & Lincoln, 2005). The process of research adopted is theoretically influenced by symbolic interactionism and hermeneutics, such that meanings are viewed as derived through social interactions with others and the individual is considered the expert in his lifeworld.

Chapter Four: Methodology and Methods

Chapter Overview

Following on from the discussion of the philosophical assumptions of this research presented in Chapter 3, the following chapter outlines the methodology and methods used to conduct this study. The chapter begins with discussion of the research methodology, followed by the methods and rationale used to select participants and participating trusts, and discussion of data collection methods. The chapter continues with presentation of the data analysis methods, this includes the coding strategy adopted, the use and integration of memos and the constant comparative technique. The importance of researcher reflexivity is also considered and in particular its significance within a Constructivist Grounded Theory (CGT) approach. The final section considers risks to participants, measures taken to address ethical issues and the procedure used to recruit study participants and conduct research interviews.

4.1 Research Methodology

As discussed Chapter 3, an initial assessment of qualitative research approaches led to the identification of Grounded Theory (GT) as the most appropriate for use in the present study. GT is a systematic yet flexible research strategy that facilitates the development of explanatory models through the use of rigorous analytical data collection and analysis procedures (Charmaz & Mitchell, 1996; Hutchison, Johnston & Breckon, 2010). Exploration of extant literature revealed the broad classification of GT studies as constructivist or objectivist, which is largely determined by the philosophical and theoretical assumptions made during the research process. In Chapter 3, the researcher established the constructivist orientation of the present study and accordingly a *Constructivist Grounded Theory* methodology is adopted.

4.1.1 Grounded Theory Method

Despite epistemological variation within approaches to GT there are a number of fundamental phases and activities considered essential for the development of theory in a GT study (Glaser & Strauss, 1967; Glaser, 1978, Charmaz, 2006). The phases and activities shown in Table 4.1 collectively comprise what is known as the G*rounded Theory Method* (GTM) (Charmaz, 1983, 1990; 1995a; 2006; Glaser, 1978; 1992; Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin, 1994). In this section the author will describe each of these components in order to illustrate the strategy used to develop the substantive theory produced during the qualitative phase of this research.

Table 4.1. Key components of the Grounded Theory Method (GTM)

Component	Description
Iterative research process	Data collection and analysis phases are concurrent, and inform ongoing sampling strategies, hypothesis testing, and emergent theory production
Coding	Coding is the first analytical step and is used to segment the data whilst simultaneously labelling it for the purpose of categorising, summarising and accounting for each piece of data collected
Constant comparison	Constant comparison occurs between data and incidents within the data to extrapolate emergent categories and their properties
Memo Writing	Memo writing is a reflective activity that illuminates theoretical notions about the data
Theoretical sampling	Theoretical sampling is used to select cases that establish links between core categories and verify understanding of emergent theory
Theoretical saturation	Theoretical saturation occurs when no new ideas about core categories emerge in newly collected data
Theory production	The outcome of a GT study is the production of substantive / formal theory, with emphasis usually on the former

An Iterative Research Process

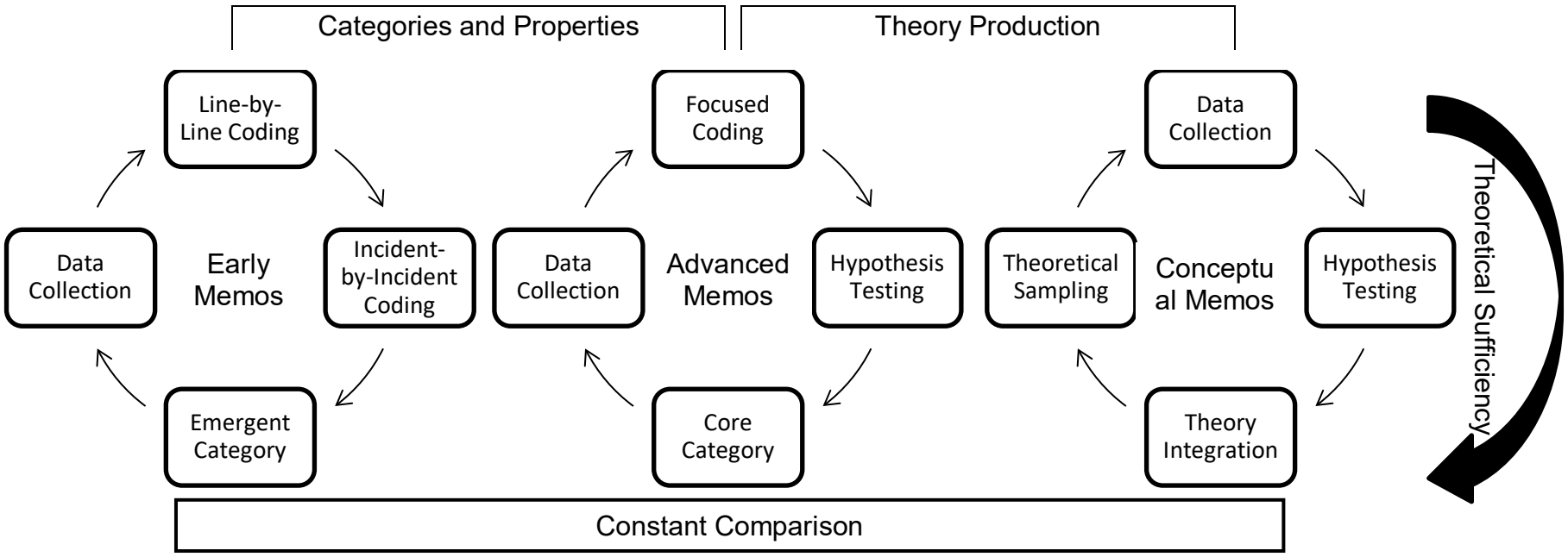
The most significant feature of a GT study is simultaneous involvement in data collection, analysis and theory development. This iterative research strategy involves the use of early analytic work to inform subsequent sampling and data collection procedures (Charmaz, 2006; Harris, 2015; Hutchison et al, 2010). Figure 4.1 illustrates the grounded theory process adopted in the present study. Application of this iterative strategy promoted the flexible pursuit of emergent areas of interest within early participant interviews. For example, the first research interview conducted in this study highlighted the *'individual interaction between a service-user and a member of staff'* as a key indicator of adult safeguarding quality within an organisation. Subsequent interviews included exploration of the importance of staff engagement on the front-line and one-to-one interactions. This dynamic approach to data collection and analysis focuses GT studies on the collection of data around emergent themes and categories thereby grounding it in an empirical area of inquiry (Charmaz, 1995a).

Coding

The first analytic step in a GT study is the process of coding data. Coding involves segmenting the data, whilst simultaneously applying a label / code for the purpose of categorising, summarising and accounting for each piece of data collected (Charmaz, 2006; Bryant & Charmaz, 2007). Coding allows the researcher to *'move beyond concrete statements in the data'* to develop analytic interpretations (Charmaz, 2006, p.43). In order to raise a code to a conceptual category a

researcher must define and explain it, specify its conditions and develop predictions based upon their analysis (Charmaz, 1990). The types of coding used in GT studies include: open coding (word-by-word, line-by-line, incident-by-incident), axial coding, and theoretical coding (focused) (Glaser & Strauss, 1967; Strauss & Corbin, 1990; Charmaz, 2006). In-Vivo codes may also be generated and integrated into a developing grounded theory (Charmaz, 2006).

Figure 4.1. An illustration of the grounded theory process used in the present study



Constant Comparison

The method used to maintain the iterative research strategy outlined above is known as *constant comparison*. Constant comparison involves rigorous and ongoing comparison between data and incidents within the data to extrapolate emergent categories and their properties (Glaser & Strauss, 1967; Charmaz, 2006). An incident may be checked against incidents that have occurred across a range of data types including field notes, memos and observations, or incidents may be recurrent within the same interview (Glaser & Strauss, 1967; Charmaz, 2006). Due to the iterative nature of theory building the process of constant comparison among incidents within the data is inherently flexible and may often be based upon memory (Glaser, 1967). Constant comparison was used throughout the data collection and analysis phases of this research.

Memo Writing

Memo writing is used for the purpose of reflecting on emergent categories, and to illuminate the researcher's theoretical notions about what is going on in the data (Glaser & Strauss, 1967). This pivotal step in the analytical process allows the researcher to explore his ideas about data analysis thus far and determine subsequent data collection steps (Charmaz, 2006). Memos are written spontaneously, vary in length and use informal language to capture the researcher's immediate thoughts about the data (Glaser & Strauss, 1967). The types of memos used in GT studies include: early memos, advanced memos and conceptual memos (Charmaz, 2006). The memos that were produced during this research will be discussed further in Chapter 4.

Theoretical Sampling

Memo writing and constant comparison lead directly to theoretical sampling. Theoretical sampling is used to develop emergent theory by sampling participants or study settings for their ability to verify understanding, discover variation or gaps in the data, or establish links between core categories (Charmaz, 1995a; Glaser & Strauss, 1967; Glaser, 1978). As theoretical sampling is used for the purpose of refining theory it is dependent upon the researcher having already identified categories and associated properties within the data (Charmaz, 2006; Harris, 2015). Theoretical sampling was utilised during different stages of data analysis in the present study, in line with the researcher's developing analytic competence, albeit was heavily relied upon during the latter stages of analysis.

Theoretical Saturation

Theoretical saturation is closely related to theoretical sampling and occurs when new ideas about core theoretical categories are no longer emerging in the data collected (Charmaz, 2006). Glaser further defines saturation as *'the conceptualization of comparisons of….incidents which yield different properties of the pattern, until no new properties of the pattern emerge'* (Glaser, 2001, p.191). Contemporary literature reveals divergent views regarding what constitutes saturation, with many GT studies criticised for making illegitimate claims regarding the saturation of categories and a lack of consistency in usage of the term (Dey, 1999). Indeed, it is suggested that the term 'saturation' in itself may be interpreted as the frequency of something occurring or the

quantity of data required to saturate theoretical categories, which undermines the fundamental processes of GT (Charmaz, 2006; Stern, 2007). Dey (1999) purports *'theoretical sufficiency'* is a more appropriate indication of the end of data collection, which places emphasis on the adequacy of data and the fullness of coding (Dey, 2004, 2007; Charmaz, 2006). The researcher asserts that the aim of data collection in the present study was to achieve *'theoretical sufficiency'* for the substantive area. The data collected was considered theoretically sufficient when no new theoretical insights were emerging.

Theory Production

Consideration of theory in a GT study spans a range of theory types from everyday working hypotheses to complex grand theories (Glaser & Strauss, 1967). Theory generation resulting from application of the grounded theory method is predominantly substantive with some studies focusing on the formal area of enquiry (Hutchison et al, 2010; Harris, 2015). Glaser & Strauss (1967) recommend focusing on one area or the other, or a specific combination of both, as the strategies for arriving at each are varied. The present study focused on developing a substantive theory of the implementation and development of adult safeguarding in mental health trusts through comparative analysis between and among groups of individuals within three NHS Trusts. There is some discussion of the formal area, *Implementation Science*, in Chapter 6 and its relationship to the substantive theory produced is considered in Chapter 7.

Constructivist Grounded Theorists

Constructivist and objectivist grounded theorists differ in their use and adaptation of the principles of theory building outlined above and may emphasise some aspects more than others (Charmaz, 2006). A constructivist grounded theorist views both data and analysis as socially constructed through shared experiences and relationships with participants (Charmaz, 1990; 1995b; 2000; 2001; Charmaz & Mitchell, 1996). In contrast, an objectivist grounded theorist views the data as an end in itself and would not attend to the social context within which the data has emerged (Charmaz, 2006). Furthermore, an objectivist grounded theorist would argue for a structured order to the use of grounded theory steps, whereas a constructivist grounded theorist places greater emphasis on understanding the social context and situations, thereby adopting a more fluid approach to this process (Charmaz, 2006).

Researcher reflexivity is thus essential to the development of constructivist grounded theory. In order to remain reflexive throughout the grounded theory process the researcher must acknowledge their presuppositions and theoretical proclivities and how these impact the emergent theory (Charmaz, 2006). Thus, it is necessary to make explicit one's consideration of how prior research experience, decisions and interpretations made during the research process influence the resultant theory (Charmaz, 2006). In the present study, the researcher's conscious awareness of her influence over the production of theory grew through her experience of adopting a

constructivist GT methodology. Examples of such influences are provided in the next section.

4.2 Research Methods

The term 'research methods' is broadly used to describe the tools and strategies adopted by a researcher to collect and analyse data (Flick, 2009). As discussed above, the present study adopted a G*rounded Theory Method* (GTM); a research strategy that features a number of phases and activities considered essential to the development of theory (Charmaz, 1983, 1990; 1995a; 2006; Glaser, 1978; 1992; Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin, 1994). Studies that adopt a GTM strategy may incorporate a range of methods for participant selection and data collection. Methods used for the selection of participants in Grounded Theory (GT) studies include: initial sampling, convenience sampling, purposive sampling, snowball sampling, and theoretical sampling (Charmaz, 2006). Data collection methods are also varied when using a GTM approach and can include: in-depth interviews, observations, surveys, written accounts (researcher / participant), and other forms of textual data such as reports and historical documents (Charmaz, 2006).

Data analysis within a GTM approach is more definitively structured and involves an iterative cycle of coding and constant comparison. Adaptation of the specific steps involved in coding data when adopting a GTM strategy differs according to the two main approaches to GT. More specifically, objectivist GT approaches, which are generally

attributed to Glaser & Strauss (1967) and Strauss & Corbin (1993), view theory as emergent (Glaser & Strauss, 1967; Glaser, 1978), while constructivist GT affiliated with Kathy Charmaz (2000, 2006), views theory as socially constructed. Both approaches have a series of steps for coding and advocate flexible use of the coding phases, albeit both begin with open coding (Charmaz, 2008).

However, the coding stages themselves differ between the two approaches and the paradigm model proposed by Strauss & Corbin (1993) is more structured than the constructivist approach proposed by Kathy Charmaz (2000, 2006, 2008). Objectivist approaches include the following coding stages: open coding, coding families (Glaser & Strauss, 1967; Glaser, 1978) / axial coding (Strauss & Corbin, 1993), and selective coding. On the other hand, constructivist grounded theory includes: open coding (line-by-line), incident-by-incident coding, focused coding, and theoretical coding (Charmaz, 2003, 2006). The coding strategy adopted will often depend on the complexity of the textual data being analysed (Charmaz, 2008). The present research is constructivist in orientation and therefore adopts the coding strategy outlined by Kathy Charmaz (2000, 2006). This will be discussed later in this chapter.

Of considerable importance when selecting methods to undertake a research study is the appropriateness of the method to the task at hand (Flick, 2009). For example, a study that is inductive in nature with the aim of exploring lived experience would most

appropriately adopt an intensive interviewing method (Charmaz, 2006). Accordingly, the methods used in the present study were appropriate to the research methodology and the practicalities of the research with regard to available resources and the timescale of the project. In the subsequent sections of this chapter, the methods used to select participants and collect and analyse data, will be discussed in detail. In addition, the procedure used with study participants to collect the data will be discussed, and the steps taken to ensure the research was ethically compliant will be outlined.

4.3 Participant Selection

Consistent with the dynamic development of theory when utilising a GTM strategy, the use of sampling methods to select study participants is also dynamic in a GT study (Morse, 2007). The sampling methods used in GT studies typically include: initial sampling, convenience sampling, purposive sampling, snowball sampling, and theoretical sampling (Charmaz, 2006; Fernandez et al, 2002; Morse, 2007). Each of these sampling methods may or may not be appropriate at different stages of the research and should be selected accordingly. The sampling strategy adopted in the present study was two-fold as it involved the selection of participating trusts and also the recruitment of individuals within each of the participant organisations. The sampling strategy was therefore multifaceted and incorporated convenience, purposive, snowball and theoretical sampling, during different stages of the research.

4.3.1 Sampling Strategy

Initial Phase

Convenience sampling usually occurs at the beginning of a research project where participants are selected on the basis of accessibility. The aim of convenience sampling is to establish the dimensions of a research topic by sourcing individuals / cases *'who are available, have already gone through, or have observed the process'* (Morse, 2007, p.234). In the context of the present study, 22 NHS mental health trusts provided their consent to be contacted about future research participation during the scoping survey (see Chapter 2). Data collected about individual trusts was extracted from the survey data and used to identify the initial convenience sample. The extracted data is shown in Table 4.2 and includes information regarding the organisational structure, the provision of training, and arrangements for the monitoring of adult safeguarding within the 22 trusts.

Table 4.2. Survey data extracted for initial sampling purposes

	NHS Mental Health Trusts																					
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**
Lead Post																						
Exists	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Level	8B	8B	-	-	8B	8A	8A	8A	8C	8A	8B	7	8A	8B	8A	8A	8A	8A	8B	7	-	8B
Years Active	½	1/2	-	-	1/2	1/2	4+	4+	1/2	1/2	1/2	2/4	1	1	2/4	1/2	2/4	4+	2/4	1	-	2/4
Plans to implement	-	-	Yes	Yes	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	No	-
Strategic Leadership																						
No. people	2	2	3	3	4	1	4	3	2	2	5	4	5	3	2	4	2	NR	3	5	5	4
Team																						
Exists	No	No	No	No	Yes	No	No	Yes	No	No	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	No	Yes
Duties																						
Hrs. per week	40	20	20	60	60	40	20	80	20	60	60	60	40	20	40	40	60	40	60	60	NR	80
Hrs. are enough	No	No	No	No	Yes	No	Yes	Yes	No	No	No	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	No	Yes
Staff Training																						
Bands 1 to 7																						
Bands 1 to 8A	✓									✓												
Bands 1 to 8B																						
Bands 1 to 8C												✓	✓									
Bands 1 to 8D			✓																			
Bands 1 to 9		✓		✓	✓	✓	✓	✓	✓		✓			✓	✓	✓		✓	✓	✓	✓	✓
Annual Report																						
Exists	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Yrs. producing	NR	1	2	-	6	1	5	4	-	-	3	2	2	2	4	2	4	5	2	1	-	2
Customised Policy																						
Exists	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Link to MA policy	Yes	Yes	Yes	Yes	Yes	Yes	-	Yes	No	-	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Reporting System																						
Digital	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No
24-hr. access to information	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes

Table 4.2 shows that the majority of trusts identified a substantive lead post for adult safeguarding; however there was variation with regard to the length of time these posts were operational and 3 trusts did not identify a lead post. In addition, some trusts were producing an annual report for a number of years while others weren't producing a report; also the provision of 24-hour access and the adult safeguarding reporting system was digitised in many trusts, while others were still operating a paper-based system. This information indicated variation in the level at which adult safeguarding was embedded across NHS mental health trusts in the UK and suggested that some trusts were at a more advanced stage of implementation than others. Indeed, examination of the data returned by trust no. 21 shown in Table 4.2 could be suggested to illustrate poor progress in terms of implementation in comparison with trust no. 8.

In order to establish the dimensions of the research topic and the trajectory of the overall process, it was assumed that trusts with an established infrastructure for adult safeguarding would produce good data, due to having already gone through the process. However, it was thought that trusts that appeared to be making less progress would better facilitate discussion of the challenges associated with establishing effective adult safeguarding practice. Of further consideration were the settlement classifications of the areas served by the trusts, particularly in relation to factors associated with urban or rural areas that may be perceived to enhance or impede good practice, which was identified as another possible dimension. The aim of initial sampling was, thus, to select a combination of trusts that served urban and rural areas that were between a medium-

to-advanced stage of implementation, with the aim of including less optimal examples later in the study.

The criticisms associated with sampling in qualitative research differ to criticisms of sampling more generally. For example, attempts to balance a sample across a range of demographic criteria may be beneficial for a quantitative study; however, this may result in too much variation within a qualitative study and a loss of focus (Morse, 2007). This presented a possible limitation of the initial sampling strategy outlined above, which needed to be minimised. As such, a further rationale for the selection of trusts was to ensure that those who were invited to participate might elaborate upon ideas that had emerged within some of the open-ended survey responses[18]. More specifically, differences between the provision of adult safeguarding in mental health and learning disability settings; barriers to practice attributed to the actions of service-users; evidence of a protective / defensive culture; the *'attitudes of old school staff'* impeding practice; and the existence of an advanced organisational structure in some trusts, were considered particularly relevant to the developing picture of adult safeguarding in mental health. It was determined that individuals who shared greater insights within their open-ended survey responses had the potential to provide rich data.

[18] Please see Appendix 4a for open ended survey responses

This type of sampling, known as purposive sampling, places emphasis on the sample being representative of the experience in question with the aim of ensuring the research becomes saturated with information on the topic (Bowen, 2006). Purposive sampling usually occurs soon after the initial analysis has begun and in many GT studies would be used following the commencement of interviews; however due to the existence of some qualitative survey data it seemed pertinent to incorporate this within the initial sampling strategy. Criticisms of this approach are predominantly fuelled by quantitative assumptions that the intentional selection of participants will incur bias (Morse, 2007). However, assumptions such as these overlook the fundamental premise of qualitative research, which is to engage a homogenous sample of participants who have experience of the topic in question (Morse, 2007). For the purpose of initiating first contact, individuals within each organisation had to be identified. Convenience sampling was again used to identify individuals via the survey data, who had responsibility for operational or strategic leadership and had provided their consent to be contacted about future research participation.

Active Data Collection Phase

At the commencement of data collection the researcher identified all individuals who were actively involved with the implementation of adult safeguarding in each trust. Subsequent to the analysis of early interviews and in accordance with the sampling recommendations of the CGT method, the researcher aimed to align subsequent sampling with emerging trajectories. For example, some participants identified specific individuals as having influenced improvements to adult safeguarding practice within their trusts. In some cases, this was related to their disciplinary background i.e. social care, nursing, and/or child protection. Indeed, individuals with a social care background were highlighted for instigating positive change. The researcher thus sought to maximise the potential of including individuals in the sample with specific backgrounds who could share their views about how approaches to safeguarding differed within different settings and disciplines. However, as there were a small number of individuals with strategic / operational responsibility for adult safeguarding in each trust, the individuals mentioned during early interviews and the individuals identified independently by the researcher at the commencement of the study, were one and the same. Accordingly, the researcher ensured that individual perceptions of how specific disciplinary backgrounds might have influenced the development of adult safeguarding within services was explored during subsequent interviews.

Snowball sampling also occurred during this stage of data collection, albeit somewhat naturally. Snowball sampling occurs when study participants refer or recommend other

potentially relevant individuals to participate in a study (Lopez & Whitehead, 2013). This technique is useful when a participant sample is representative of a marginalised group who are not accessible via conventional methods (Green & Thorogood, 2009). Due to the unstructured nature of adult safeguarding in trusts with a less established infrastructure there were occasions where study participants volunteered information about other potentially relevant individuals. Snowball sampling is frequently criticised for its inability to produce a sample that is representative of the population. While this is significantly more applicable to quantitative research, a potentially more relevant criticism of snowballing within the context of qualitative research is the likelihood that study participants will nominate individuals who will present the most favourable view (Bryman, 2016). Accordingly, the researcher took steps to minimise the impact of such biases over the emerging theory. As is shown in the diary extract presented in figure 4.2, participant X (adult safeguarding co-ordinator) recommended having a conversation with the Director of Nursing about the trust's training record to glean a more strategic perspective. It can be seen that the researcher made note of the recommendation made by participant X and instead posed the same question to participant Y, before seeking out the Director of Nursing. Further exploration of this particular discussion point in subsequent interviews resulted in data saturation and as such there was no requirement to approach the Director of Nursing.

Figure 4.2. Diary extract to illustrate the use of snowball sampling

'Participant X suggested I should ask this question directly to John Doe…I could potentially justify this by including John Doe[19] as my exec lead at the trust. I haven't made contact with John Doe yet, but I did ask the question directly to participant Y, who suggested that yes it's important, but we run the risk of making safeguarding about compliance rather than an ethos that should be embedded within the culture. She suggests that if we are going to focus on ticking boxes we have no hope. She did also say that she will contact Jane Flitwick (performance lead) for me, although she is fearful that her knowledge of safeguarding will be limited to what she gleans from her (participant Y). I'm reluctant to include Jane Flitwick in the sample if her knowledge is limited; this is bound to result in poor data, but I will contact John Doe'

(Researchers Diary Notes, 2011)

This combination of snowball and purposive sampling continued for some time during the early stages of data collection. As the analysis of interview data progressed and became more advanced the sampling strategy incorporated the identification and inclusion of negative cases, i.e. participants who expressed a contrasting viewpoint regarding a concept or phenomenon compared to the majority of study participants (Morse, 2007). Using the example of the emergent category related to the positive influence of individuals with a social work background on the enhancement of adult safeguarding practices, a negative case is identified. In particular, one participant viewed the collaborative partnership between social care and health care services as a barrier to establishing good practice within their organisation. It was suggested that if resources were available to contain all community related safeguarding issues within

[19] All names have been changed to protect the identify of study participants

the community mental health team (CMHT) this would be a more optimal approach than a collaborative partnership. This was in contrast with the views of the majority of study participants who viewed collaborations with social care positively and was therefore treated as a negative case. Consistent with GT sampling principles, negative cases such as these were integrated into the substantive theory to provide a more comprehensive understanding of major and minor categories. In addition, subsequent interviews with participants included attempts to further explore negative cases of this kind until no new ideas were emerging.

The penultimate phase of sampling relied heavily upon theoretical sampling. As discussed, theoretical sampling is the strategy used to develop emerging theory by selecting participants for the purposes of, verifying concepts derived from the study data, discovering gaps or variation in the data already collected, or substantiating core categories (Charmaz, 1995a; Glaser & Strauss, 1967; Glaser, 1978). To this end, theoretical sampling is integral to the process of coding and data analysis in a GT study. In the case of the present study and the aforementioned small number of eligible participants, theoretical sampling informed the development of substantive theory through analysis of interview data, identifying a concept or category, altering interview schedules to include questions to explicate further the identified category, the removal of irrelevant questions from interview schedules; and pursuing a wider understanding of a category by varying the questions in subsequent interviews until the category was fully understood within its substantive context.

An example of the use of theoretical sampling in the present study is provided in Table 4.3 below. Table 4.3 documents the emergence of an issue concerning middle managers and the uptake of adult safeguarding within organisations through a series of interviews. More specifically, middle managers were identified as a barrier to implementation and highlighted as a particularly hard-to-reach group. From the earliest indication of this issue, the researcher included a variety of questions in interviews to explore further the different ways, in which, levels of management were perceived to have impacted the effective use of adult safeguarding practice in organisations. This use of theoretical sampling led to the development of *Management Level Barriers* as a minor category that was later related to the major category of *Challenges to Effective Implementation.*

To add a further dimension the researcher sought to include middle managers in the study sample; however, this proved difficult due to busy work schedules. One middle manager was successfully sampled and some middle managers recommended other relevant individuals from within their clinical team to participate in the study. For example, a Prison In-reach Service Manager identified a senior practitioner within her team who was involved with adult safeguarding and interviewed as part the study. In addition, an attempt was made to divide the participant sample into operational / strategic leads, but this was unsuccessful. Generally, people who agreed to participate were directly involved with adult safeguarding and spoke about if from both an operational and strategic perspective. They were also experienced enough to provide

substantial information about the barriers to adult safeguarding, including blocks at management level.

Table 4.3: A table to illustrate the use of theoretical sampling in the present study

Interview	1	2	3	4	5	6
Question	Can you identify any specific barriers to adult safeguarding?	Have you had any specific issues with managers?	Do you think that aspects of the role of being an operational manager, makes it harder for them to embrace it?	It's so important to reach middle managers isn't it, because if they're not on board, that will filter down to the front line?	So you're talking about operational managers. Why do you think it's been so hard to get them on board?	In instigating a culture change, have you had a particular focus on addressing issues with middle managers?
Response	I think audit is a part of the solution. I think there's a cultural thing as well though in terms of managers actually, managers need to see this as part of their day job to be honest and they need to recognise that this is a key part of their role. Managers are not sufficiently contributing and we end up with workers running around chasing their tails.	We've had one team dealing with 42 AS cases and one dealing with four. No reason why it should be different really, but something is wrong. I can see why it's right in the first team, because we have a very pro-active manager, who manages the process and puts out the right messages about how things should be dealt with.	Yes I think so….there's so much more to look at and safeguarding is just like 'oh no it's huge, it's big'….we've got a lot of work to do at the layer of middle managers.	Yes, and I suppose at the moment, what we're doing, if I think about it, we're managing that by compensating and sort of helping out more in the practice areas.	I think that I don't feel that it's as high a priority as other things. Now I don't know whether that's because they're from a nursing background rather than social work. You know, there's nobody from a social care background at that level and I wonder whether that has a big influence.	Yes, we've been through a significant structural change as we are very general management focused – transactional, control, command. We're trying to devolve those responsibilities and empower people at the front line. Because challenging cultural practice is a big part of the problem.
Contribution to theoretical development Major-category: *Transitioning* Minor-category: *Leadership*	Uptake of managers is a key issue – explore how they are impacting effective implementation.	The leadership style of operational managers has an impact on how adult safeguarding is used at the front line.	Middle managers may be overwhelmed by the enormity of the adult safeguarding agenda.	Exec-team compensate for blocks at middle management level by working directly with people at the front-line, in the form of support and advice.	In addition to the influence of middle managers on the uptake of adult safeguarding by front-line staff, their disciplinary background may determine whether or not it is prioritised.	A strategy adopted to address issues concerning middle management is a managerial restructure that eliminates unnecessary levels of management.

Sample Size

The sample size in a GT study is not pre-determined as the aim is to attain good quality data that reflects the optimal participant experience (Morse, 2007). It is suggested that targeted research interviews produce better quality data, which results in the need for fewer interviews and research participants in qualitative research studies (Morse, 2007). In addition, as researchers are limited to conceptually processing small amounts of data at any one time, excessive data collection potentially impedes data analysis and theory production (Morse, 2007, p.233). The aim of data collection in the present research, therefore, was to collect good quality data that was *'significant, pertinent, informative and exciting'* and directly related to the research topic (Morse, 2007, p.233). The end of data collection was signified by the sufficiency of the data collected in terms of the adequacy and completeness of theoretical categories and their properties (Dey, 1999). The data collected within three NHS mental health trusts was sufficient for the production of substantive theory in the present case.

4.4 Data Collection

4.4.1 Interviews

The main method of data collection used in this study was semi-structured interviews. Semi-structured interviews encourage two-way communication and are considered an appropriate method to yield meaningful and detailed information about a process; hence they are often seen in GT studies as the main source of interpretive information (Charmaz, 2006). Semi-structured interviews are also commonly used in studies that focus on the development, implementation and effectiveness of policies within national services (Cabinet Office, 2009). Consistent with the progressive nature of the present research, semi-structured interviews were identified as the most appropriate means to explore in-depth the learning from the scoping phase. More specifically, the use of semi-structured interviews allowed the researcher to facilitate discussions with participants across areas that expanded upon the broad areas covered in the scoping survey (see Chapter 2). This included: implementation of adult safeguarding, the development of adult safeguarding practice and policy, and practitioners' personal views of adult safeguarding practice within their trusts. The specific questions used during initial interviews with study participants are shown in Table 4.4[20].

[20] The prompts and probes associated with interview questions can be seen in the full interview schedule located in Appendix 4b.

Table 4.4: A list of questions used during initial interviews with research participants

Topic Area	Interview Question
Implementation	Can you tell me how safeguarding adults has been implemented at this trust?
	What staff interventions have worked well and why?
	In your opinion have staff members at this trust fully embraced adult safeguarding?
	What strategies have been used to ensure that service users are aware of their right to be safe / protected?
Practice	Can you tell me about the adult safeguarding practices and procedures currently operating at this trust?
	In terms of current practices and procedures, what works well and why?
	What historical / current practice and procedural issues exist?
	What other embedded practices and procedures overlap with safeguarding practices and procedures?
	How would you describe the organisational attitude to adult safeguarding at this trust?
	Can you describe any incidents / initiatives, historical or otherwise, that have influenced change to organisational attitudes / attitudes of specific groups to safeguarding adults?
	Can you describe the main barriers to adult safeguarding at this trust?
	Can you describe the specific obstacles faced when attempting to safeguard adults with mental health difficulties?
	How would you rate existing adult safeguarding practices at this trust? 1 to five (high)
Policy	Can you explain your involvement with the development of the adult safeguarding policy at this trust?
	How does the policy work in practice?
	How is understanding and awareness of policies and procedures measured / examined?
	How are decisions made about different elements of the policy?
Personal Views	In your view how important is it for service users to feel safe and protected whilst in trust care?
	Some researchers suggest that traditionally mental health services have been reluctant to tackle the problem of abuse. How do you respond to this suggestion?
	Some people suggest that it is easier to ensure that children and adults with learning difficulties are protected than adults with mental health difficulties. What are your views?
	Some researchers suggest that existing safeguarding practices and procedures limit the rights of services users with mental health difficulties. What are your views?
	What are your views on personalisation?
	In your opinion what improvements should be made to adult safeguarding practice at this trust?
	What three words best describe adult safeguarding practice at this trust?
	Is there anything else you'd like to discuss / add?

Table 4.4 shows that during initial interviews a broad range of questions were included to explore fully the perceived circumstances of the development of adult safeguarding practice in NHS mental health trusts. The use of a semi-structured format, however, allowed the researcher to be flexible in adhering to the preconceived questions listed in Table 4.4. This allowed for the development of theory that was relevant within its substantive context and co-constructed by the study participants and the researcher, consistent with the GT research methodology discussed. Indeed, in accordance with the sampling strategy outlined in the previous section, during the intermediate and latter stages of data collection, interview questions were based entirely upon emerging theoretical concepts derived from the data collected in prior interviews. A further strategy used to adapt interview schedules in line with the developing theory was the inclusion of questions that reflected the researcher's examination of literature on the topic.

More specifically, where study participants highlighted 'triggers' that prompted improvements to existing practices, in the form of guidance documents or public inquiries, these were subsequently examined by the researcher and where appropriate incorporated into research interviews. For example, *"The Report on the Consultation of the Review of 'No Secrets'"*, suggests that NHS Systems should, *'create a culture of openness towards safeguarding concerns, and promote organisational learning from incidents'* and *'empower frontline staff to understand professional and employment obligations and the level of conduct required to safeguard patients within their care'*

(DH, 2009, p.51). This report was highlighted as having instigated improvements in the area of adult safeguarding, hence questions were asked directly to adult safeguarding leads about strategies used to create an open culture and empower frontline staff.

4.4.2 Diary entries, field notes and supervision notes

The researcher's field diary was also an important source of data in the present study. More specifically, notes were recorded in a research diary during participant interviews, discussions with individuals in the field, and attendance at safeguarding meetings or conferences. Reflective notes were also made subsequent to research interviews with study participants and fieldwork generally. These notes were heavily relied upon for sampling purposes and were also used to aid the production of conceptual memos. They were particularly important during data analysis when a participant displayed a particular body language accompanied by a tone of voice that would not be succinctly conveyed within an interview transcript. The availability of field notes allowed the researcher to reflect on her perceptions of participants' reactions to interview questions, their communication style and engagement with the researcher during interviews.

Supervision notes and the researcher's journal were also an invaluable resource during this study. In particular, supervision notes and the research journal were used as a means to reflect on the ongoing data collection and analysis, provide an overview of the study development as a whole and monitor its progress. For example, reflections on

ongoing interviews were regularly discussed during research supervision for which notes were prepared prior to each meeting. The documented notes and the discussions that took place between the research team often resulted in moments of crystallisation regarding the developing theory. For example, the realisation that differences with adult safeguarding approaches at an organisational level, were predominantly associated with the organisations approach to service delivery, the organisational culture and the culture of the local area, occurred during a supervision meeting. Subsequent to supervision meetings further reflective notes were made and used to aid the production of conceptual memos. Examples of research diary entries, field notes and supervision notes are provided in Table 4.5.

Table 4.5: Sample extracts taken from the researcher's diary, field notes and supervision notes

Diary Notes	Field Notes	Supervision Meeting Notes
One of the questions I was trying to answer with my PhD was why mental health services are so far behind other services in terms of adult safeguarding? I think that in comparison with children's services, older adult mental health and LD services etc. - the reasons given are generally the same as those suggested within the literature. For example, legislation, public inquiries, more experienced staff in LD services, thresholds and the prevailing historical culture in mental health that perpetuates social inequalities. Something that keeps coming up as a barrier is the dominance of the medical model and the lack of integration with social care. I need to explore this further. Service users are not at the centre of any discussion. Most people are more concerned about the awareness of staff, than the actual experiences of the service user. For most of the people I have interviewed, improving their current practices and finding ways to help staff understand, recognise and become more familiar with reporting, is the most important thing.	Participant X seemed very passionate about adult safeguarding and discussed a lot around her role and how it has been instrumental in improving adult safeguarding arrangements at the trust. She was very nice and very open in comparison with some of the other people I've interviewed. She specifically discussed, the types of strategies she used i.e. workshops, one-to-ones with team managers and visiting teams on an ad hoc basis. She seemed to reveal an overreliance on the safeguarding team, suggesting that staff pick up the phone to ask any question about safeguarding. She talked about the increase in the number of calls made since she first started and the team are now inundated with queries. She did express a feeling that there is an overemphasis on accountability and too much responsibility for safeguarding placed on individual roles, rather than it being embedded in culture.	The differences between individual trusts seem to be about organisational culture and culture of the local area. For example in Trust X it has been suggested that the authorities are very political and this seems to have shaped how services have been developed, implemented and delivered. At a more individual level, specific roles and people involved with safeguarding have been identified as instrumental in improving safeguarding practice. I think there's a lot more that could be explored about relationships and effective communication. All three cases so far seem to echo the same timescale, within which observable improvements have been made and these improvements have generally been associated with the introduction of new roles and recognition at a strategic level that safeguarding should be a priority.

4.5: Data Analysis

4.5.1 Coding

Research interviews were transcribed and coded manually from the outset using the method outlined by Charmaz (1995a, 2000, 2006). More specifically, the initial coding stage involved the use of an open strategy whereby interview transcripts were coded *line-by-line* with annotations recorded in the margins. The purpose of this initial coding approach is to help the analyst to focus on what is emerging in the data without forcing theoretical assumptions upon it (Charmaz, 1995a, 2000, 2006). By coding line-by-line it is possible to separate the data from participant and researcher assumptions and examine it afresh (Charmaz, 1995a, 2000, 2006). Initial coding also involved the identification of similar incidents within and between interview transcripts, such that codes were generated to represent a reoccurring incident. This strategy is known as *incident-to-incident* coding and was particularly useful for grouping similar incidents in the data together (Charmaz, 2006).

Table 4.6: An example of *line-by-line, incident-to-incident, focused, theoretical* and *In-vivo* codes in the present study

Raw Data	Line-by-line	Incident	Focused	Theoretical	In-vivo
Q. You talked a little bit about leadership at a managerial level. Do you think it's been embraced at an executive level, from your own observations?					
A. Um, to a point, but I think not. Well if I say for example…..I'm not saying anything that I haven't said directly to managers. I think if they were taking it seriously, then we would not have a professional lead for safeguarding children and adults, we would have a professional lead for safeguarding adults only. And the point I've made…..the proportion of your services that you provide directly to children is minimal, why are you not focusing that attention on adults who are 90% of your client group.	-Partially embraced -Being up front with everyone -Not taking AS seriously -Should not have a combined AS and CS lead role -Need a lead role for AS only -Majority of MH services are for Adults -Less than 10% of services are for children -Should be focusing on AS	**Issues of AS tagged onto CS*	Evidencing the neglect of MH trusts to take responsibility for AS	Disengagement	**Taking it seriously*
Q. A number of survey respondents said that they are reliant upon being tagged on to child protection. You know, those people who are flying the flag for AS are saying that they're 'kind of lost out there in the wilderness, hoping to benefit from the processes that are set up for child protection'.					
A.I mean obviously there are synergies, and I don't know if that's the right word, but there are obvious links, but the two things are quite different. And Sheena herself has said it is much different in terms of adult protection. The type of work, the profile of abuse, the whole remit of investigation, the lack of legislative framework, all those sorts of things are much different in adults than they are in children. And for a trust, who is both a provider and has investigative responsibility, I just think you need that sort of level of expertise, especially as it's a very big trust, which has to work across several authorities.	-synergy between AS and CS -if not synergy, a link (searching for correct expression) -but AS and CS are very different -AS Lead at the Trust has discussed the differences -differences explained -emphasis again on the differences -Trust has multiple responsibilities -giving personal opinion about level of expertise required -Trust has to work collaboratively	**Differences AS / CS*	The importance of recognising the difference between AS and CS and the extent of responsibility	Inadequate integration strategies	**Synergy* **Abuse profile* **Remit of investigation,* **Legislative framework* **Trust as provider and investigator*
Q. In terms of future relations with the Trust then, where would you like to see it go?					
A. I would like to see some buy-in to the multi-agency safeguarding hub. I think that would be a good starting point….the trust knows, as I do that there are managers within the CMHTs who are very	-buy-in -multi-agency safeguarding hub -managers are uncomfortable -managers don't see it as part of their job	**Problems with*	Reluctance of managers to	Disengagement 'managerial'	

uncomfortable with this as an area of work, who don't see it as part of their job, who lack the confidence to do it and who actually will always delegate it to a junior member of staff and tell them to get on with it. Um, well that's fine, except that our local procedures and national procedures, require there to be some management input into investigations because it involves deployment of staff and also it's an organisational risk….the remaining LD services that the trust provided are of a very poor standard for a very challenging client group and a lot of abuse has arisen as a result of practices there…that's an issue that has rumbled on and rumbled on	-managers lack confidence -managers always delegate -junior team members take responsibility -local and national requirements for management input -involvement of staff = organisational risk -LD services are of a poor standard -occurrences of abuse due to poor standards -ongoing issue	*managers*	engage with AS Recognising risks and consequences Implications for service users	-consequences / implications

*Adult Safeguarding
**Child Safeguarding

Examples of line-by-line and incident-to-incident codes are provided in Table 4.6[21]. The table shows that line-by-line codes reflect what is being said in each line of the data extract, whereas incident-to-incident codes label an incident within the data to signify its recurrence. The next stage of coding involved the development of focused codes. Focused codes are more analytical in nature and are used for the purpose of categorising data using a term that represents the meaning of a statement (Charmaz, 2006). This strategy provides a means to handle the data succinctly, freeing the analyst to move across transcripts and data to compare participants' *'experiences, actions and interpretations'* (Charmaz, 2006, p.59). Table 4.6 also provides examples of focused codes that were developed during the present study. It can be seen that, in comparison with initial codes (line-by-line / incident-to-incident) focused codes are more conceptually based.

An example of In Vivo codes developed during the present study is also provided in Table 4.6. In Vivo codes are common terms used by participants that represent their meanings, views, experience or collective perspectives (Charmaz, 2006, p.55). Participants may assume that such terms are widely used; however they are very often most significant to a particular group or within a specific context (Charmaz, 2006). For example, participants in the present study consistently used the term 'taking it seriously' throughout interviews. This particular term was important to participants and was discovered to have multiple meanings related to whether or not organisations were

[21] Examples of raw coding can be seen in Appendix 4c

engaged with the adult safeguarding agenda. For example, in the coding sample presented in Table 4.6 the absence of a substantive lead post for adult safeguarding is offered by a participant as evidence of an organisation not 'taking it seriously'. Contrastingly another research participant provided examples of strategies used with staff during adult safeguarding training to affirm that her organisation were 'taking it very seriously'. The identification of terms such as these and integrating them into the analysis enhanced the conceptual understanding of participants' social worlds.

The final stage of coding involved the development of theoretical codes. Theoretical codes are used to conceptualise *'how the substantive codes of a research relate to each other as hypotheses to be integrated into a theory'* (Glaser, 1978, p.72). More specifically, theoretical codes are used to articulate the relationships between the categories developed during focused coding (Charmaz, 2006). In developing theoretical codes many researchers invoke coding families that exist within their respective disciplines (Glaser, 2005) For example, researchers working within a symbolic interactionist school-of-thought may be tempted to seek evidence of a Basic Social Process (BSP) within their data (Glaser, 2005; Charmaz, 2006). However, criticisms of this analytical approach highlight the potential of novice researchers in particular, to force their data into preconceived theoretical frameworks (Glaser, 2005). In order to remain open to the potential utility of a variety of analytic schemes (Glaser, 2005) a pre-existing theoretical coding family was not aligned with the data collected in the present study. Rather, guidance for conducting theoretical coding was used to extensively

examine the focused codes developed during this study for underlying theoretical concepts.

Table 4.6 provides a sample of theoretical codes developed during the present study. The table shows that evidence offered for the neglect of NHS mental health trusts to uphold responsibility for adult safeguarding has been assigned the theoretical code *'disengagement'*. During the final stages of analysis this code was relabelled *'Evidence of Disengagement'* and aligned with the subcategory *'A Prevailing Culture of Disengagement'* which became a conceptual component of the major category *'Challenges to Effective Implementation'*, as shown in Table 5.2. The process of arriving at the final categories and subcategories presented in Table 5.2 involved extensive examination of the codes by the researcher and her supervisors. Codes were organised into categories and subcategories, and as such during the earlier stages of analysis these were greater in number[22]. The final codes, categories and subcategories presented in Table 5.2 are those that were most conceptually representative of the process involved in implementing adult safeguarding practices and procedures in NHS mental health trusts.

Furthermore, interplay between the theoretical constructs uncovered and their relationship to the overarching research question was also considered. This led to the

[22] A sample of categories and subcategories pre-narrative integration can be found in Appendix 4d

identification of a potential alignment between the emerging theory and implementation science, which is the systematic study of how specified activities and strategies are used to implement evidence-based policy within specific settings (Proctor et al, 2009). The researcher's consideration of implementation science was, however, a latent aspect of the study and considered during the latter stages (Chapter 6) to facilitate a better understanding of *Barriers* and *Facilitators* of good practice across healthcare settings generally.

4.5.2 Memos

The use of memo writing is fundamental to the development of substantive theory in a GT study; resultantly memos are considered an essential source of data (Lempert, 2007). Indeed, memos are integral to the process of data collection and analysis, as they are the pivotal step between coding raw data and conceptualising research findings (Charmaz, 2006). During the production of memos the analyst makes comparisons between the data, codes and categories and formalises ideas about emergent theory to provide direction for subsequent data collection steps and theory development (Charmaz, 2006). The types of memo typically seen in a GT study include early memos and advanced memos (Charmaz, 2006). Early memos are commonly written about an individual interview or case study, whereas advanced memos usually reflect the analyst's personal narrative of ideas about codes, categories and emerging theory (Lempert, 2007; Sbaraini, Carter, Evans & Blinkhorn, 2011).

In the present study, early memos consisted of the researcher's reflections on individual interviews or cases and contained initial impressions of participants' experiences accompanied by some early interpretations about what might be emerging within the data. Table 4.7 provides an example of a case-based memo produced during the present study. The memo presented in Table 4.7 discusses an example of when an executive team within an NHS mental health trust were reluctant to raise a safeguarding alert despite there being evidence of considerable safeguarding concerns for the individuals involved. The format of the memo illustrates how the researcher documented her own interpretations of conversations with study participants alongside her personal learning from each interview. Memos such as these were produced following each interview.

Table 4.7: An example of a case-based memo produced during the present study

Case-based Memo
Participant X was very frank and honest about the problems facing her trust with adult safeguarding. She suggested that, from her point of view, having come from a social care background, the trust were underperforming in terms of safeguarding. In terms of why this might be the case, she discussed the same issues as other trusts, such as process, procedure, lack of understanding of what safeguarding actually is, understanding individual responsibilities and also knowing how to make alerts and referrals. Within her role, she has focused on improving training and building the safeguarding team. I explored whether or not she thinks there is an overreliance on the safeguarding team - she agreed and talked about the fact that she doesn't feel 100% supported by the Exec team. She gave an example of a case where some foreign nationals, who were under the care of a local gentleman, had agreed to participate in a clinical trial. The Exec team were keen to include the foreign nationals in the trial, as they had agreed to be filmed throughout. Participant X was immediately suspicious of the circumstances and brought it to their attention; however the team couldn't see that there may have been a potential safeguarding issue. Participant X had several discussions with the team before they would actually agree to raise an alert / referral - soon after this the foreign nationals disappeared. She used this example to explain what she is up against at the trust and claims that in this case the desire for public recognition was more important to some professionals. She suggests that the local area and not just the trust can be a very political place and this certainly has a negative impact on placing the needs of the service user at centre of all activity. Additionally, while she accepts that a lot of responsibility is placed on her as the Exec lead and she understands that somebody has to be held accountable she didn't think this should be the case further down the line of management i.e. with the Safeguarding Lead, but she suspects that perhaps this has to do with the culture of the trust, often being about blame, roles and job descriptions. I learned a lot from this interview, especially about the personal motives of individuals and how these ultimately impact 'doing the right thing'. I was quite stunned and appalled that people in executive positions would overlook such glaringly obvious safeguarding concerns without question. For me, this begs the question *what is really going on at the level of the Executive team*? This seems to be a barrier in Trust 2, as other participants have said similar things. What I'm quite surprised about is that they each don't seem to be aware that their colleagues have similar concerns about how safeguarding has been received within the organisation. Is there a fundamental communication issue here? Are the people responsible for implementing adult safeguarding too segregated from each other? There are clearly underlying issues at this trust with a 'blame culture' but I sense that this is an issue with the organisational culture at this trust and not just specific to safeguarding. In terms of leadership Participant X sees herself as a soldier in combat. She is at the helm, leading the way and prepared to accept accountability as the Exec Lead…she is also prepared to take the flak for those who are in lower level positions. She sees herself as their protector…interesting!

The advanced memos produced during the present research were more analytical and written in a more structured format. They specifically focused on emerging categories and their subcategories and sought to examine and establish the conceptual facets of occurrences within the data. An example of a conceptual memo produced during the present study is provided in Table 4.8. The example provided in Table 4.8 is an illustration of work undertaken during the conceptual development of the category '*Leadership'*. It can be seen that the researcher conceptualises the actions of the participant during her interaction with the executive team, but also the actions of the exec team during this interaction, as described by the participant.

In addition, the leadership style of the participant is explored within the memo and integrated with background literature. This is a minor deviation from classical approaches to GT, which recommend delaying the incorporation of literature until the analysis is complete, so as to allow for the emergence of theory (Glaser, 1978; 1992; Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin, 1993). As the present research adopted a constructivist stance the ad-hoc examination of literature was essential to this iterative process. This integration of literature also ensured that the researcher was conversant in contemporary ideas and concepts within the research area, so as to competently facilitate discussions with study participants. A comprehensive review of existing literature, however, was not undertaken until all data collection and analysis was complete.

Table 4.8: An example of a conceptual memo produced during the present study

Conceptual Memo

Managerial Style in LEADERSHIP

As the Exec lead for adult safeguarding, Amy has a difficult role to play. She is faced with multiple challenges in a trust deemed to be below the baseline level for adult safeguarding (CQC assessment 1 year prior). She is addressing these challenges in a number of different ways including communication campaigns, scrutinising serious case reviews and serious incidents, scenario based learning with front-line staff and challenging the seeming dominance of the medical model at her trust. Strikingly, however, she identifies the executive team at her trust as one of her greatest barriers to improving practice.

'And that is the challenge I've had with senior directors at this Trust. Can I just give you another example of something that happened recently?...there is a local gentleman who owns a business, who came across a number of young men, who were all using heroin. He brought them to (local area) and got them in touch with our substance misuse services with the aim of treating them and getting them back into meaningful employment and wanted to make a documentary film of it all. He's being portrayed as a bit of saint, this guy, and he might be…so we had a conversation (exec team) and it turns out these men are living in his house and he's starting to get a bit twitchy because they're misbehaving, still using, causing mayhem, stealing, getting up to all sorts. So I said, I'm not suggesting you stop the treatment…it sounds like a safeguarding issue to me. "No, no, no, no, no, we've assessed them and they're all safe". Right, so what do we know about this man then? So in the end, I had to say no, safeguarding, I want you to raise an alert. And a week later, they still haven't done it because they didn't really want to do what I was asking them to do. Do you want to know what my take on it was? My take on it was that the ego of a man who owns a Sikh television company, filming some people getting better off heroin and that we might attract some publicity around that for said lead people - clinicians. That was my take on it. So obviously eventually I had to put a bit of a bomb up some peoples backsides in the week.'

'So what I've said is that I want all the people who were involved in that…not to blame but to talk through, and do it in a reflective way, their thought processes for why we got to that situation and why it had gone on for so long. And then kind of overlay that with safeguarding and principles and how that should have gone. I think, I suppose the key for me is tackling from behind services. So I guess we're almost working backwards, I guess not backwards, but from the top down. I mean if the people at the top aren't getting the challenge. I was cross at the lack of understanding'

She seeks evidence of understanding of the responsibility of the organisation for protecting vulnerable adults at the level of the executive team during a meeting. She doesn't receive affirmation of their ability to recognise a safeguarding issue, so prompts them by questioning a concerning situation. She is initially careful to broach the issue with diplomacy and respect for her colleagues and the clinical needs of the patients concerned. Their failure to recognise the potential seriousness of the issue contributes to her use of an instructive managerial style to issue a request for an alert to be raised. Although, she remains professional, she struggles to conceal her disapproval of their actions. She further constructs her own personal interpretation of their strategic motives for their inappropriate response. She reacts with a range of emotions from confrontational action, to intermediary negotiator, to personal disappointment. She resolves herself to the enormous challenge she is facing by simply stating 'there's a lot of work to do'.

In this example the exec team, whose responsibility it is to deliver adult safeguarding, have negated this commitment. The success of adult safeguarding depends upon strong leadership that permeates from the most senior level to the front-line (DH, 2011); this is clearly lacking in this organisation. The National Competence Framework for Safeguarding Adults emphasises the responsibility of senior managers to ensure that their organisation is fully committed to SA and 'have in place appropriate systems and resources to support this work in an intra and inter agency context' (Galphin and Morrison, 2010). The Exec Team in this case are entirely non-compliant, but are also possibly unaware of these responsibilities. A closer examination of Amy's leadership style, however, reveals admirable leadership qualities (see trait and dispositional theories). She is passionate about protecting vulnerable adults and approaches her executive role with honesty and integrity. There is also potential evidence of *transactional and transformational* leadership (Burns, 1978; Bass, 1985). She is initially considerate in her response to her colleagues, but assumes a more authoritative approach when she foresees that the wrong course of action may be taken.

4.5.3 Constant Comparison

Consistent with the GTM method discussed, the data collection and analysis phases of the present study were concurrent. Constant comparison was utilised throughout to ensure that both the collection and analysis of data was rigorous and continually contributing to the developing theory. This involved the continuous comparison of data and incidents within the data across the range of data sources discussed above i.e. field / diary notes, interview transcripts, memos. Due to the flexible nature of this strategy comparisons are often based upon memory; however the researcher used her research diary to document meaningful discoveries and keep track of the ongoing analysis and developing theory. A conceptual illustration of the iterative research strategy employed in this study can be seen in figure 4.2.

4.5.4 Reflexivity

At the beginning of this chapter the constructivist orientation of the present research was established and in particular the researcher's position and influence with regard to the co-construction of theory was acknowledged. The detailed discussion of methods used to collect and analyse data in the present chapter evidences the reflexive nature of a constructivist grounded theory approach. Indeed adoption of GT methods themselves requires a considerable amount of reflection on behalf of the researcher. For example, activities such as memo writing, the use of reflective field notes and diary entries, and undertaking constant comparison, enhance researcher reflexivity. To further explicate researcher influence over the research process, exploration of one's tacit and

experiential knowledge is encouraged (Belenky et al, 1997; Cutcliffe, 2001). It is suggested that *'to bring such knowledge into the open, to discuss how it has affected theory development'* improves methodological rigour, transparency, and the overall quality of research findings (Cutcliffe, 2001, p.1479; Mruck & Mey, 2007).

Reflexive Statement

Subsequent to graduating with a first class honours degree in Psychology and Counselling the researcher took up paid employment in two roles; one as a behaviour mentor in a secondary school working with children who were excluded from mainstream classes and the other as a support worker in a Child and Adolescent Mental Health Services (CAMHS) team. The experience gained in these roles coupled with a background in psychology and counselling ignited the researcher's already fervent compassion for those suffering from mental illness and a desire to contribute to the development of interventions that enable them to cope better with daily living. Having experienced the vulnerability of many young people first-hand and read numerous disturbing accounts of abuse in personal case-files, the researcher was struck by the opportunity to contribute to a project that sought to challenge the provision of protection to those who are most vulnerable in society via completion of a PhD.

Early attempts to identify a research question reflected the researcher's interest in psychological research and in particular her interest in ethical decision making in

relation to the assessment of capacity to give consent. Initial areas of focus included the capacity of vulnerable persons to consent to sexual relationships within mental health services in response to allegations of abuse going unchecked (NPSA, 2006; Johnson, 2006). The researcher was also very interested in the complexity of ethical decision making in mental health due to the ambiguity surrounding human rights legislation and determining vulnerability. Some of the motivations for pursuing avenues such as these were undeniably related to the researcher's desire to bring such issues to the fore in an attempt to emphasise the importance of tackling abuse head-on. Additional motivators were potentially of a personal nature and related to the researcher's long-standing disdain of all forms of abuse or manipulation of those who are vulnerable.

On the advice of her supervisors the researcher withdrew from identifying a specific focus too early and immersed herself in background literature on the topic of abuse and neglect in mental health. She discovered that of particular dominance within the literature was the concern that mental health providers were not taking responsibility for protecting those in their care. This was of particular interest to the primary supervisor at the time due to his background in mental health nursing, his established career in adult protection and elderly care, his personal assertion that large organisations that harbour abuse must be held to account, and his influence and involvement with large scale investigations of institutional abuse. His vested interest in the topic was of no doubt a precursor to identification of this area of focus. Confident that the selected topic was

worthy of investigation and under-researched with the potential for considerable development the researcher embarked upon exploring this area further.

During the developmental stage of the study, the researcher's conscious awareness of her influence and that of her supervisors, over the research and the developing theory grew. It became apparent to the researcher that her learning through conversations with her supervisors, practitioners in the field and initial exploration of background literature were shaping the design and development of the survey questionnaire and the study as a whole. In addition, learning from the survey findings provided topics for discussion in research interviews and equipped the researcher with a comprehensive knowledge of the area to facilitate conversations with practitioners. However, the researcher became aware of the need to ensure that topics were explored critically and succinctly so as not to allow dominant voices to overshadow potentially important issues expressed by those of a meeker voice.

Of further note was the researcher's upbringing and in particular her father's background in industrial relations and behaviour change in organisations. More specifically, her exposure to the bureaucracy of large organisations through her father's work led to on the one hand, presumptions about the characteristics of individuals in positions of power and an unnecessary suspicion of their motives. And on the other hand a tendency to collude with participants when providing justifications for

unacceptable behaviour on behalf of staff members. In order to minimise the potential for attitudes and assumptions such as these to distort the developing theory and analysis of research findings the researcher carefully examined her thoughts and feelings recorded in her diary and field notes. In addition she regularly shared her presumptions, interpretations and analysis with her supervisors to engage in open discussion about other potential interpretations and perspectives. Activities such as these, her developing competence as a researcher and the practicalities of learning in action, solidified her constructivist epistemological position, which was now evidenced within a multitude of data sources.

4.6 Research Ethics

During the design and development of a research study all potential risks to participants must be identified and the legitimacy of the research to relevant stakeholders must be established (BPS, 2009). For the purpose of ensuring that research is ethically compliant researchers are advised to consult ethical guidelines. Due to the researcher's membership of the British Psychological Society (BPS) the guidelines consulted during the design of the present study included the *Code of Ethics and Conduct* and the *Code of Human Research Ethics* (BPS, 2009). In addition, during submission of the study for independent review by a Research Ethics Committee (REC), the National Institute for Health Research (NIHR), the Health Research Authority (HRA) and the National Research Ethics Service (NRES) guidance documents were consulted. The specific risks to participants associated with non-clinical studies include:

recruiting before consent; threat to privacy and / or subject safety; participants being subjected to undue influence to take part in the research; participant becomes distressed; breach of confidentiality, including release of identities and/or personal information (NRES, 2010). The steps taken to ensure the present study was governed by the aforementioned principles for the purpose of minimising risk and to ensure a valid contribution to knowledge was achieved are outlined in the next section.

4.6.1 Risks and Ethical Issues

Study Population

The study population for this research consisted of three NHS mental health trusts, with an estimated maximum of twenty-four participants in total. The specific target group were individuals with leading responsibility for developing and implementing adult safeguarding policies, practice and procedures, at a strategic or operational level or with expert knowledge of its everyday application. Additional requirements for participation were: 18 years or over, English speaking, and employed by an NHS mental health trust (contract / voluntary). Due to the depth of discussion required during interviews a reasonably good understanding of the English language was necessary for participation. As the acquisition of a reliable translation service was not within the remit of the project funding non-English speakers were excluded from the study.

Recruitment

Recruitment during the present study occurred in two stages. Firstly an invitation email was sent to the safeguarding lead practitioner in each of the three identified trusts containing the study protocol, information and consent sheets[23], a copy of the researcher's research passport and relevant REC and R&D approval letters. Lead practitioners were invited to collaborate with the researcher to identify (initially) other relevant individuals within their organisation who may be eligible to take part. The researcher contacted all eligible persons by e-mail in the first instance and provided a study information sheet with a request to follow-up with a phone call to discuss their participation. Participants were encouraged to read the information sheet and direct any questions to the researcher by email in the first instance.

Informed Consent

A willing participant must *'have the time to share the necessary information; and they must be reflective, willing and able to speak articulately about the experience'* (Charmaz, 2010, p. 26). On the day of the interview, the researcher discussed the contents of the information sheet, explaining what participation would involve. This included matters such as, confidentiality, digital recording, anonymity and the storage of data. The researcher checked that participants understood the information provided sufficiently enough to make an informed decision to participate. Participants were also

[23] Please see Appendix 4e for the participant information pack

reminded of their right to withdraw from the study at any time before, during or after the interview, except following the submission of a manuscript for publication. Participants were then asked to give their written consent to participate using the consent form provided.

Procedure

Participants took part in a one-to-one interview with the researcher that lasted between sixty to ninety minutes; semi-structured interview questions can be seen in Table 4.5 in this chapter. Participants were interviewed in their place of work in a room affording privacy for confidentiality and recording purposes. While the questions were not of a sensitive nature, participants were made aware that protocols were in place for reporting disclosures of criminal activity. In addition, participants were informed that should they feel distressed by a line of questioning the interview would be paused with the opportunity to reconvene at the participant's discretion. Post-interview, participants were given the opportunity to discuss their participation, including their thoughts and feelings about the interview questions. Participants were asked to remain contactable for up to six months post-interview for the purpose of clarifying aspects of recorded interviews if required. In addition, they were advised to contact the researcher should they wish to review their transcript or receive a summary of the study findings; researcher contact details were provided.

Storage of data

Digitally recorded interviews were transcribed, anonymised and stored on a password-protected database with hard copy transcripts stored in a locked filing cabinet. Any personally identifiable information that had to be retained for study purposes was stored in securely encrypted files. For the use of direct quotations, written consent was sought from participants for the use of quotations from interviews. Quotations that contained personally identifiable information were either not used, or were used in an abridged form to maintain anonymity. Audio recordings were destroyed twelve months after the analysis was completed. The study file, including hard copy anonymised transcripts, was retained in a locked filing cabinet for five years.

Ethical Approval

This study was granted ethical approval on the 07th March 2011 by the *West Midlands Research Ethics Committee*[24]. The study also underwent an Independent Peer Review at Staffordshire University and received approval on the 31st January 2011. Both reviews determined that the study was of scientific merit and ethically sound. Approvals were also sought via the Research and Development (R&D) offices of each of the participating trusts for the purpose of receiving the clearances required to undertake research at the individual sites.

[24] Please see appendix 4f for ethical approval documents

Conclusion

As discussed in the present chapter, the research methodology adopted in this study is *Constructivist Grounded Theory*, such that grounded theory steps are used flexibly with emphasis placed upon understanding the social context and situations under which the phenomenon occurs. This study utilised a range of data collection and analysis methods associated with the Grounded Theory Method (GTM). This specifically included the use of convenience sampling, purposive sampling, snowball sampling and theoretical sampling, each selected according to the needs of the research during different stages. Data collection methods included one-to-one semi-structured interviews, supervision and field notes, and memos. In accordance with Constructivist Grounded Theory coding stages, line-by-line, incident-to-incident, focused and theoretical coding were utilised in this study. The researcher maintained the reflexivity required of a GT approach through continuous reflection recorded in her research diary, and a variety of memos. The methods used were varied and complex and required considerable attention to detail. In the next chapter the results of this qualitative research study will be reported.

Chapter Five: Findings

Chapter Overview

The following chapter presents the findings of the qualitative phase of this research. In particular the substantive theory produced following the collection and analysis of data using the Grounded Theory Method (GTM) will be presented. The chapter begins with discussion of participant demographics including relevant details about the participating NHS trusts and individuals who were interviewed during the study. This is followed by an overview of the substantive theory organised across major and minor categories. The chapter continues with presentation of the integrated theoretical narrative; this is discussed across three major categories and inter-related sub-categories that explain the process of implementing adult safeguarding in three NHS mental health trusts. The categories discussed include: *Establishing Structures, Processes and Procedures; Challenges to Effective Implementation;* and *Transition to a Progressive Future.*

5.1 Introduction

Consistent with the methodological approach outlined in Chapters 3 and 4 a substantive theory of adult safeguarding was developed through interviews with adult safeguarding practitioners in three NHS mental health trusts. More specifically in depth interviews were carried out with strategic and operational leads for adult safeguarding and analysed using a Constructivist GT approach. The analytic approach used was iterative in nature and incorporated diary notes, field notes, supervision notes and memos. In the following sections the researcher will present the results of the qualitative phase of this research.

5.2 Participant Demographics

A total of 16 individuals working within 3 NHS Mental Health Trusts and their corresponding Local Authorities were interviewed between 2011 and 2013.

5.2.1 NHS Mental Health Trusts and Local Authorities

At the time of data collection two (66%) of the participating trusts were providing mental health, learning disability, community care, and forensic services within urban and rural areas. One trust (n = 1; 33%) was a provider of mental health services exclusively to a large ethnically diverse urban area. One (33%) trust was also providing specialist services in the areas of perinatal mental health, eating disorder, and children's mental health, regionally and nationally. All three (100%) trusts had a substantive lead post for

adult safeguarding; two posts were operational (66%) for between 2-4 years along with an extended safeguarding team and one was operational (33%) for less than one year with no additional team members. All three (100%) trusts were producing an annual report and had a trust level customised policy that was linked to the local multi-agency policy. All three (100%) trusts worked collaboratively with their Local Authority (LA) around all safeguarding matters.

5.2.2 Study Participants

Participants included 13 (81%) women and 3 (19%) men ranging in age from twenty-nine to sixty-four years. Ten (62%) were strategic leads for adult safeguarding and 6 (38%) indicated that their leadership responsibilities were operational. Two (12.5%) participants were in their current post for 1 year, 2 (12.5%) for 1.5 years, 4 (25%) for 2 years, 1 (6%) for 3 years, 3 (19%) for 4 years, and 4 (25%) were in post for 6 years or more. Table 5.1 shows the employment level, safeguarding (SG) remit, main area of practice, and disciplinary backgrounds of research participants. Sixty-eight percent (n = 11) were working in adult safeguarding or adult and child safeguarding combined, the remainder (n = 5; 32%) were working in related areas such as patient safety, risk and domestic violence. Thirty-seven percent (n = 6) were working in mental health (MH) or learning disability (LD); 19% (n = 3) were working in prison in-reach or forensic services; 25% (n = 4) were responsible for all areas of service; and 19% (n = 3) were employed within the LA. Eight (50%) participants had a professional background in nursing, 4

(25%) in social care, 1 (6%) in psychiatry, and 3 (19%) had worked predominantly in adult / child safeguarding across multiple local services.

Table 5.1. Employment level, SG remit, practice area, and disciplinary background of participants

	No. of participants per trust				
Categories	Trust 1	Trust 2	Trust 3	Total (*n*)	Total %
SG Remit					
Adult Safeguarding	2	2	2	6	37
Adult and Child Safeguarding	1	3	1	5	31
Infection Control, Patient Safety, Risk	1	1		2	13
Women, Domestic Violence and Sexual Safety			1	1	6
Non-specific	2			2	13
	6	*6*	*4*	*16*	*100*
Employment Level					
Director / Associate Director	2	3	1	6	37
Manager / Head	1	1	1	3	19
Consultant / Lead	1	2	2	5	31
Co-ordinator	2			2	13
	6	*6*	*4*	*16*	*100*
Area of Practice					
Mental health	1		3	4	25
Learning disability	1			1	6
Mental health / Learning disability	1			1	6
Prison In-reach	1			1	6
Forensic		2		2	13
All areas	1	3		4	25
Local Authority	1	1	1	3	19
	6	*6*	*4*	*16*	*100*
Background					
Nursing	2	3	3	8	50
Social Work	2	2		4	25
Psychiatry	1			1	6
Child / Adult Safeguarding	1	1	1	3	19
	6	*6*	*4*	*16*	*100*

5.3 Findings Overview

Implementing adult safeguarding practices in NHS mental health trusts: initiating, transforming and sustaining

The findings of this study have been organised across three major categories and associated subcategories that are shown in Table 5.2. The implementation of adult safeguarding in NHS mental health trusts relies upon the establishment of robust structures, processes and procedures, and existing systems do not adequately support effective practice. This is evidenced by a lack of referral data for mental health; disengagement and opposition among staff members at all levels from the front-line to the executive team; and characteristics that are specific to mental health environments that enhance the complexity of delivering effective practice. Operational and strategic leads for adult safeguarding adapt numerous strategies to enhance practice and improve uptake and engagement. This includes: promoting organisational transparency; adopting flexible leadership styles; devolving unnecessary levels of management; and improving partnership working. NHS mental health trusts are transitioning from the '*internalised culture'* that was once typical of these environments to a progressively more transparent outlook, as identified by study participants. In the next section the qualitative findings of this research are presented in an integrated theoretical narrative.

Table 5.2: Categories and associated subcategories derived from interview data

No.	*Category*	*Subcategory*	*Codes (general)*
1	*Establishing structures, processes and procedures*	*Dedicated posts and teams*	• Introduction, benefits and drawbacks of dedicated posts and teams
		Training and supervision	• Types and levels of training • Impact and applicability of training • Uptake and engagement • Importance of supervision
		Reporting	• Process • Trends • Performance and performance related issues
		Audit and monitoring	• Indicators of good practice and associated challenges • CQC assessments
2	*Challenges to effective implementation*	*The complexity of delivering SG in mental health settings*	• Ethical dilemmas • Mental illness and abuse: a calamitous relationship
		A prevailing culture of disengagement	• Evidence of disengagement • Historical features that contribute to disengagement
		Staff perceptions, attitudes and responses	• Challenges at the front-line • Understanding, recognition and acceptance of responsibility • Response to investigations • Hard to reach groups
		Management level barriers	• Buy-in at the level of middle management • Engagement at executive level is an issue
		Health and Social Care services	• Integration vs. segregation • Differing philosophical approaches
3	*Transition to a progressive future*	*Then and now: promoting cultural change*	• Former SG culture • Facilitators of cultural change
		Leadership	• Leadership approaches and challenges
		Strategies for improvement	• Devolving responsibilities / transformational change • Improving multi-agency engagement • Recruitment strategies

5.4 Theoretical Narrative

5.4.1 Establishing Structures, Processes and Procedures

The successful implementation of adult safeguarding within NHS organisations is reliant upon the establishment of structures, processes and procedures. Data related to this has been organised across five sub-categories: *the introduction of dedicated posts and teams*; *training and supervision*; *reporting*; *audit and monitoring*; and *assessment*. Analysis of interview data indicates that NHS mental health trusts are actively establishing supportive structures for adult safeguarding in the form of dedicated posts and teams. However, practice and performance issues suggest that the existing processes and procedures in mental health do not adequately support an effective safeguarding culture.

Dedicated posts and teams

Introduction

The introduction of dedicated posts and teams positively contributes to the establishment of effective safeguarding practice within NHS mental health trusts. As participant 2, a lead for adult and child safeguarding explains, the introduction of dedicated posts for adult and child safeguarding brings expertise and credibility to the role that formerly would have been considerably lacking.

P2. *'Yeah, because they bring a certain expertise to it…she gave a certain credibility to that sort of debate and discussion, whereas before it'd have been, somebody's just having a bit of a moan about it, you know'*

Lead nurse roles have also been instrumental in setting up processes and governance procedures for adult safeguarding. Participant 16, the head of safeguarding at his trust, highlighted that as part of the reorganisation of his trust lead nurses were assuming greater responsibility for safeguarding with the potential to improve the depth and dispersal of adult safeguarding knowledge across the trust.

P16. *'So each area will have its own lead nurse and those lead nurses are sort of the local lead for adult safeguarding so we should be able to…get to a position where I'm going to them for information about safeguarding'*

Benefits and Drawbacks

Despite certain positives surrounding the introduction of dedicated posts and teams there was also apprehension regarding the time pressures within which to demonstrate impact. Participant 13, an adult safeguarding manager, expressed her concerns about the potential that contracts would not be renewed. She expresses her excitement, but also feels under pressure to make an impact.

P13. *'Yeah and it's really exciting, but really scary. We've got a whole new team starting and um, I think it's a perfect mix, but it can make you feel slightly insane at times. I think the pressure is because it is like a year post…and the climate now is, unless they make a difference, they will not have a job at the end of it'*

Further concerns about the introduction of specialist teams and posts were associated with the possibility that staff members would take less ownership for adult safeguarding. This would negatively impact the development of capability across the multitude of staff groups and the challenge associated with addressing this issue was a daunting and frustrating prospect for participants 12 and 16.

P12. *'What you've got to be careful of is that they don't end up being like a call centre, because it is about developing capability, isn't it? And I have this with my safeguarding team; they were just inundated with calls…you might be developing capability with the person that you're on the end of the phone to but my god, we've got 3,500 staff, how are you …it's going to take forever'*

P16. *'We get about between ten and twelve calls a day asking for advice and I get a sense that rather than people actually taking responsibility for these issues themselves, because they know that they can pick up the phone and talk to us, that that is how they deal with safeguarding issues'*

The increasing numbers of staff seeking advice from safeguarding teams suggests that awareness among staff members is improving; however this was perceived as an indication that safeguarding is not yet embedded. Participants 2 and 16, elaborated upon the specific problems arising from an over reliance upon safeguarding teams and the misconception of staff members regarding their role and function. They acknowledge the positives associated with staff members taking action; however, their concerns about the absence of knowledge and awareness of the process are palpable.

> P16. *'Now that's good…but I think that might be an indication that it's not mainstreamed yet! You know – safeguarding is a XX issue and that can also cause confusion because some people think that by talking to us, they've raised a safeguarding alert and it's always a bit of a surprise to them when I say "now, actually you now need to formally raise an alert with the local authority". They think that it's job done when they've spoken to us sometimes'*

> P2. *'When you contact our team for advice, you are not making an adult safeguarding referral, because there's still that misunderstanding and I think we have to be really clear. You're phoning for advice. The advice might be, yes make a referral or it might be, no absolutely, you've got all these safeguards in place, sometimes people quite often will phone me to say is this okay. Do I need to make a referral?...you're phoning the trust, the trust is not a referral agency'*

Training and Supervision

Types and Levels

A variety of training types are offered across the different levels of staff employed within NHS mental health trusts. Participants 1 and 2 explain how training varies from basic awareness training that is compulsory for all staff, to investigation training for senior staff with leading responsibility for investigations and how this is achieved.

> P1. *'We've got other people in the Directorate trained, all directorates have people trained at the lower level for just recognition of abuse…so you know it's done on inductions, safeguarding training courses, we have to have regular updates, child protection is annual, depending on whether you're a clinical member of staff or whether you're a manager or whatever'*
>
> P2. *'…the investigation training is only really for senior staff because they would be leading investigations, wouldn't they. And then there's the minute taking training…whereas the in-house training is just, you know, this is what the VA process is and education as to what is a vulnerable adult? And that sort of reflective practice and getting people to think outside the box'*

Impact and Applicability

Training is commonly scenario based and often comprised of real life scenarios. This style of delivery is particularly useful for engaging staff in discussions about what might occur in practice. Participant 1, a clinical director for learning disabilities, explains how this approach encourages practitioners to reflect on their own values and the possible actions they might take in situations she identifies as dilemmatic. She concludes that ultimately staff members should know in their heart if something should be reported.

> P1. *'The scenarios help you examine your own value base…it can expose all kinds of dilemmas, you know, even down to, let's say you've got an Asian family or an Afro Caribbean family /asylum seeking family and you have concerns, what do you do? The kind of thing you'd get in a group session is what if they accuse me of being racist?* ? *It's those ethical dilemmas, you think well in the end people conclude it should not stop you reporting it. If you know in your own heart, know that you have a duty.'*

Despite the provision of training to all levels of staff, there is a limited amount of time for the delivery of training, which is often incorporated within the general induction. Participant 11 explains how much information has to be incorporated into a one-hour session, while participant 15 asserts that the amount of time dedicated to training is inadequate. Participant 1 suggests that the effectiveness of training is dependent upon

'whether an organisation takes them seriously enough' and the likelihood that staff will put their learning into action.

> P11. *'I mean the induction is we have an hour and that's to do level one child, to do vulnerable adult…don't, I know, please, it's just a nightmare. Yes, for all new staff - we have an hour. Level one safeguarding children and your vulnerable adults and in that we need to mention domestic abuse, we need to mention the MARACs (Multi Agency Risk Assessment Conference) within that'*
>
> P15. *'More training, more awareness, um people do training every three years, it's not enough'*
>
> P1. *'It's whether an organisation takes them seriously enough. So you can put as many staff as you like through the training, but unless you get things reported, they'll never even feature on the radar'*

In addition there is an overemphasis on compliance with national training requirements to achieve quality ratings, within the NHS. Participant 5, a trust-wide adult safeguarding lead at associate director level, expresses her disappointment at the lack of attendance to local authority training by health staff and shares her sentiments about the tendency of NHS services to focus on box ticking.

P5. *'…you know there's lots of training put on by local authorities around adult protection and child protection and people don't go. And they don't go because they've got to tick the box for mandatory training, so they're not red anymore they've turned green. And I think that is such a shame, because there's so much more to be gained by going and being trained in a multi-agency setting.*

Uptake and Engagement

Despite these issues and limitations effective practice is contingent upon the impact of training in practice. Participant 12, an Executive Lead, feels that staff members *'don't get it'* as she recounts a training exercise with a group of nurses where questions were raised about the appropriateness of communicating with the ex-husband of a patient who had become unwell. She is frustrated at the amount of time and effort being invested in training that is evidently not effective.

P12. *'And we got into this thing about…"oh well, if she doesn't want any of the staff to speak to him, then they mustn't"… and I had to say, well no, actually we'd have to say to mum, we're going to have to speak to ex-husband because we need to make sure that the children are ok…and I said to them all, have you been on the safeguarding training? And they all had and yes and I thought, right, ok, ok, but they're not getting it. They're just not getting it, so we're training within an inch of our lives spending a whole time equivalent on training but it isn't getting through.'*

Participant 5 also expresses concern about the engagement of staff, in particular where she is alerted to an issue within a team and subsequently learns that all staff members have received their mandatory training. Nevertheless, she acknowledges the limitations of training and later suggests that '*training is always the answer, but I'm not sure it's always the solution'*. Indeed greater importance is aligned with the action of raising a referral as highlighted by participant 4, a Service Manager.

> P5.*'…if 100% of staff are trained in adult safeguarding…well it's a different worry…what is it about that training that has again not influenced that front-line practice*. *And we all know that we've been on training, that really is, you know that we've been inspired by and we're going to make some many changes. But within two weeks, the busy day job takes over, so what is it, what is that 10% that we want people to keep hold of and put into practice'*
>
> P4. *'The raising of the issue really, is the more important aspect or conscious decision to raise it. Because once you've raised it, it is a very effective process. It is the raising of the issue and that can only be addressed by the training of our staff'*

The mandatory inclusion of safeguarding within clinical and social care supervision is a potential strategy to encourage staff members to be more invested in developing their

knowledge of adult safeguarding. Participant 6 explains how this might help the individual to reflect on their actions, as there are often questions surrounding whether or not an incident should be referred. A viable suggestion is to include safeguarding as a mandatory field within an electronic database for supervision, as is standard practice in some trusts indicated by participant 10, an Associate Director of Nursing.

P6. *'And the other thing then is for me, is about having that very specific supervision and be able to sort of properly reflect and think through decisions that we're making about the cases that we are taking to safeguarding or not. You know because we'll take some for discussion, um and people will be scratching their heads and saying - I'm not sure whether it really fits the protocols'*

P10. *'We have an electronic database for collecting information about supervision, so if you have your supervision you put it in the database. But the thing that we did in XX particularly was put in a mandatory field that you can't move past if you don't say you've discussed safeguarding'*

Reporting

Process

The process of reporting safeguarding issues requires the completion of multiple forms and varies according to the structure of trusts and designated responsibilities. Where multiple forms must be completed the process becomes onerous with little consideration of the impact this has on staff members. The increasing bureaucracy of the reporting process also negatively impacts ownership and communication between teams. Participants 2 and 5 discuss the pressures on staff members and the resulting communication breakdown that arises from the complexities of existing processes. Participant 3, an Executive Director of Nursing who is an experienced safeguarding practitioner, but new to her current post openly questions the logic of existing processes.

> P5. *'I just don't think that people realise how it can be when people are really busy on the front-line trying to do the numerous tasks that they have to do and all that recording as well. You know and they don't understand the impact of that on top of everything else that they have to do'*

> P2. *'If it's an older adult i.e. someone over 65, we don't have any ownership of it within the community mental health teams, it goes straight to the district teams…so we don't get copies – we're totally out of the loop with it really'*

P3. *'…for every adult protection referral, then the staff are going to have to do a serious untoward incident (SUI) form. And I said well, why do you think that doubling the bureaucracy of the process is actually going to encourage people to report it'*

Participants 2 and 5 commonly advocate simplifying the reporting process by eliminating the need to complete multiple forms and place greater emphasis on the importance of raising an alert. Participant 5 however, who has a background in social care, predicts resistance to such changes, while Participant 3 who works for the same trust expresses similar frustrations about resistance she has already encountered.

P2 *'I would say to people, well let's keep this as simple as we can, if in doubt, make your referral or if in doubt, raise your alert because no-one's going to give you a hard time about that'*

P5*. 'Yeah, what I'm proposing is that we cut it out of the incident reporting process and they just come to me essentially, then I'll get all of the referrals but I don't at the moment - I don't see them. It would make it easier in the sense that all they would have to do is send the referral to the place it's got to go and send a copy to me. So it's still a bit of a pain, but it's not as much of a pain as also having to do an incident report and send it to two different people as well'*

P5. *'I think there may be people in the trust who will resist this proposal, because I think there are people who feel there's a certain safety in using this incident reporting process'*

P3. *'You know and what evidence have you got that, that's actually going to make things better. And they said well, you know, we'll be able to check what they're doing. I said you'll be able to check what they're doing, if you just ask them to send a copy of the referral. And it was like, no no, it all had to be done in this sort of health way, using this rigid clinical governance model really. Um, but that must militate against people making referrals'*

In order to ensure that processes for the reporting of adult safeguarding concerns are aligned with the demands of daily practices trusts should minimise bureaucratic procedures that are burdensome for staff. As discussed in this section, practitioners are both burdened and frustrated by the disjointed nature of existing processes and concerned about a lack of staff engagement and the impact this has on day-to-day practice. Practitioners propose a number of practical strategies to minimise existing bureaucratic processes, whilst acknowledging that these may be met with resistance. As such, trusts must address these issues to ensure reporting processes are effective and efficient and aligned with mental health service user needs.

Trends

During the initial stages of implementation staff members within NHS mental health trusts were generating high numbers of referrals. This was attributed to the introduction of new referral criteria in accordance with multi-agency adult safeguarding policy, which caused staff members to become more reactive and less likely to use their professional judgement to determine when it was appropriate to make a referral. Participants 2, 4 and 5 reflect on their early experiences of generating referrals and the progress that has been made.

> P2. '*We went through a sound barrier really where we were all hyper-sensitive and everything was a vulnerable adult issue and I now think that you know we're very sensitive and sensible about it'*
>
> P4. *'Well there was a time, when everyone was learning about VA (vulnerable adult), they were making too many referrals, which I thought sometimes there were inappropriate referrals being made, but because they fitted the criteria they had to be a referral'*
>
> P5. *'No, but I think we made the error earlier on…we got lots of referrals and we tended to investigate them all, rather than using professional judgement…about whether actually it reaches the criteria'*

Of further note, are the circumstances surrounding incidents, which are evidently complex in terms of determining whether or not safeguarding intervention is required. For example, incidents that involve allegations against staff members or a *'client-on-client'* assault warrant an immediate safeguarding referral. Participants 1 and 2 explain how these reporting decisions are made.

> P1. *'If a client accuses another service user, which we do get, of hitting them or hurting them or doing something, that's automatically a safeguarding issue. Um you know any report about staff, is automatically a safeguarding issue…'*
>
> P2. *'If someone has thrown something and someone was injured and they said they didn't want anything to be done about it, you'd definitely flag that up as a client-on-client assault'*

However, incidents that are considered less serious are dealt with internally, with practitioner responses revealing a desire to minimise the number of reports so as not to reflect badly on the organisation. Participant 1, a learning disability nurse by background, speaks about her experiences in a combined mental health and learning disability trust in relation to patient-on-patient incidents and those that should be dealt with via safeguarding procedures. She dismisses the need for safeguarding in a number of situations, but assures that if a client wishes to pursue the issue it would be escalated.

P1. *'If it's very low level, let's say if someone throws something at someone and you know it missed or it might hit them, but there's no injury or we'd probably say that's an incident…we would monitor the client and ask did they want to take it further…sometimes they do and we report it as an assault. We always take that seriously - so it wouldn't be necessarily a safeguarding issue, it would be an incident…but you know what I mean, no one has come to any harm. Well no, you know, you'd clog up the system with that kind of thing'*

P1. *'You know what I mean, because to me if you report everything, it's going to look like you've got more reports, so you've got to be cautious with the figures as well'*

This coincides with local authority (LA) responses, which highlight that there is a considerable lack of referral data generated from within mental health services in comparison with other services. Participants 2, 3 and 14 share similar experiences in relation to this.

P14. *'One of the things I deal with in the mental health trust is more formally around the multi-agency procedure and when an alert should be made. So they were given information on that...because initially our numbers for referrals on safeguarding from mental health had been minimal'*

P2. *'But I just think for a county of this size, we should have more. I'm not saying we should be inundated, but we should have more adult protection referrals'*

P3. *'There is just a dearth of adult protection referrals that are coming through adult mental health services. In other services there is evidence of an annual increase in the numbers of referrals...we're not seeing that same increase in referrals in mental health'*

Participant 14, who has citywide responsibility for the application of adult safeguarding at board level, expresses her views about the dearth of referrals from mental health. She specifically cites a lack of understanding among staff members regarding the procedure for generating referrals and a tendency to rely upon existing processes such as the Care Programme Approach (CPA). She explains her reasoning for this view, highlighting the strength of multi-disciplinary working in mental health. Participant 3 echoes concerns about awareness among staff members, whilst also emphasising the issue of incomplete documentation.

P14. *'We weren't getting many safeguarding referrals, because they use the care programme approach (CPA) more effectively. They already have multi-disciplinary meetings and arenas - they're very clued up on having a different level of professionals involved in somebody's care so if somebody's been sectioned that isn't a decision taken by one person, it's a multi-agency decision. So when the safeguarding referrals were coming through from mental health, it*

was clear that more than one professional had that view that it should be safeguarding. You were getting more serious, complex ones – that's what was happening'

P3. *'My view is that a lot of documentation is not completed as required and staff remain unaware about what they are supposed to do. I wouldn't want to say that the garden is rosy everywhere else; however the garden is more overgrown in mental health…'*

Perceptions of reporting trends in mental health for adult safeguarding issues reveal some inconsistencies, from the initial surge of referrals reported in some trusts in response to the introduction of new multi-agency policy, to a dearth of referrals in mental health reported by LA representatives. Consideration of factors that influence reporting trends highlights that the decision-making process for referring incidents is complex and staff members have a considerable responsibility for making the right decision. Somewhat worryingly however, some participants emphasise the importance of upholding the reputation of the organisation, and advocate caution where the reporting of adult safeguarding issues to external bodies is concerned.

Performance and performance-related issues

Team performance with regard to raising alerts and generating referrals is considerably varied across services, with learning disability teams and inpatient wards identified as better performers. Participant 10 reflects on her training as a learning disability nurse explaining that the vulnerability of service users ensures that staff members dig a little deeper. Participant 1, who also has a background in learning disability nursing, expresses a similar view emphasising the issues with communication among learning disability service users.

> P10. *'I think it's just because we see things very differently. We always dig for more, we never really believe just what's on the surface…whereas I've found with mental health nurses, they'll say 'well this person said to me' and I will say "well that's okay that's what they think", whereas with LD, I guess it's to do with cognitive ability, you're always trying to tease out a little bit more'*

> P1. *'I think we're more aware in learning disabilities. When I say more aware, you know, I'm not doing anyone else a disservice, but for us I think we are conscious that some people we care for have major communication issues and you have to do things for them…'*

Participant 4, a Service Manager, expresses her confidence in the reliability of inpatient ward staff to generate referrals, but has concerns about the number of referrals being generated from within Community Mental Health Teams (CMHT). She explains that, despite the existence of a pathway and policy for adult safeguarding *'they've not got their head around the system'* and they are reliant upon existing processes.

> P4. *'It's not so hard with the wards I have to say. When the ward raise a VA (vulnerable adult) for whatever reason um you're fairly confident that first of all you'll get the AP1 (adult protection form), even if you don't ever get the AP1 you're guaranteed to get…the incident form. The community teams, I have to say, the older adult community teams, you hardly ever receive any. Now that's not to say that it's not happening and we've spoken to them on many occasions…'*
>
> P4. *'I think it's because if there's a VA safeguarding issue say in the XX older adult team, um I think that they ring the district team and the district team sort of sorts it out. I'm not suggesting that they're not raising concerns, but because they're sort of liaising automatically with the district team. They sort of just don't see the connection between our processes and the district processes'*

Participant 5, an Associate Director for Social Care, also has concerns about the number of referrals being generated from within CMHTs. At the time of the interview, she was in the process of investigating a team who had generated just four referrals in a year. She was suitably suspicious and keen to identify the underlying issues. She associates the success of another CMHT with the pro-active approach adopted by the team manager, as she explains below.

> P5. *'I want to try and improve our implementation of the adult protection policy in the CMHTs, because I've done an audit and it's not good. One is that they seem to be having too few referrals…they've had one team dealing with 42 adult safeguarding cases in one year and another team have four and this is not a leafy backwater you know, this is an area of reasonably high deprivation. So no reason why it should be that different really, so something clearly is wrong there'*
>
> P5. *'I mean I can see why it's right in the other team, because you know we have a very pro-active manager, who manages the process, who clearly puts out the right messages about how things are going to be dealt with'*

Forensic services are without exception the most inaccessible where the implementation of adult safeguarding practices is concerned. Participant 13, an adult safeguarding manager in a city council with responsibility for raising the bar for adult safeguarding and multi-agency partnerships, speaks of her experiences trying to

engage with forensic services. She discusses the challenges encountered and quickly disassociates herself suggesting it *'doesn't bother me'*.

> P13. '*I think in terms of the forensic teams and I don't think I'm betraying anybody's confidence here – I know because of my links with XX that the actual forensic team at XX, when XX attempted to do work with them the door was firmly closed. Absolute – I know they had real problems and challenges with them. But that's why they brought in XX – you know she runs a coaching, mentoring and action learning set, but there has been no attempt at participation in it. It's an absolute ivory tower, you know, that's impenetrable and it's all right, that doesn't bother me, because I don't have anything to do with those guys'*

Participant 15 an adult safeguarding lead in forensics, similarly airs concerns about her experiences. In particular, she discusses a lack of available data to evidence adult safeguarding activity. Nevertheless, she feels strongly that service-users are protected in other ways, as she explains.

> P15. *'To start with, I worked in the team that collects the data and it was very obvious that forensics didn't do safeguarding because when we ring them for data, we can't get anything. Now I strongly believe that actually these places are doing safeguarding, but what they aren't, is transparent in the way that we*

believe they should be...we've also got CCTV in forensics – so a lot of stuff is filmed. And it doesn't mean to say that issues don't happen, but a safeguarding investigation, isn't always in that environment the best way to deal with it. I think it's being labelled under other things. A lot of issues I felt, we were dealing with in a safeguarding way now, but they'd always been dealt with, but they probably been dealt with through complaints, or through an SUI…they felt they were being open and transparent…'

The variability in performance observed across teams, presents a challenge for operational and strategic adult safeguarding personnel, and is likely to have a marked impact on the success of adult safeguarding within and across services. The performance of teams, however, appears to be significantly impacted by the circumstances that are specific to individual settings and disciplines. Indeed, the influence of a pro-active management approach is highlighted for its positive impact on adult safeguarding activity. Accordingly, strategies for improvement must account for these differences and address the variance in experience and knowledge of safeguarding processes among staff members.

Audit and Monitoring

Indicators of good practice and associated challenges

There are multiple indicators of effective adult safeguarding practice within services. Such indicators encompass numerous areas of practice that contribute to the safety of the environment. Participant 2, who commenced *'a cycle of audit for adult safeguarding in all inpatient day units'* outlines the breadth of the areas examined. The quality of risk assessment procedures is also important and it is essential that evidence of risk of abuse or neglect is *'transferred into care plans'* to optimise the potential of incidents being prevented, as participant 2 explains.

> P2. '*Well even things like environment, you know is our environment safe? And is it welcoming, you know are people wearing I.D. badges, so you know who they are? Do you have photo boards, where it explains you know this is the unit manager…and things like PALS boards for making complaints, AS leaflets and…those kinds of things. Right through to the cleanliness aspect as well'*

> P2. *'So, one of the things I wanted to look at…where there are clear high level risks for vulnerability to abuse, um and things like serious physical health alongside serious mental illness and so on, that there's evidence that what's picked up in the risk assessment, transfers into our care plans'*

The development of reliable strategies for the purpose of auditing adult safeguarding practice is paramount. Participants 2, 5 and 13 give examples of the different strategies used in their respective trusts to conduct audits of adult safeguarding activity. One such strategy, as outlined by participant 2, involves screening SUIs (Serious Untoward Incidents) to identify incidents where safeguarding should have been considered. This strategy is used to engage in retrospective learning with staff members when appropriate referrals have not been made.

P2. *'We're linking the safeguarding risk cases to the main risk tracker, to keep track…so sometimes, we will scrutinise an SUI and we'll think that is safeguarding or it's got a safeguarding aspect, but no safeguarding referral has been made. Then we can do some retrospective work in those areas…you know what happened, why did a referral not happen? You know, a referral needs to happen, it's not happened and it's not stated here'*

P13. *'We've also introduced case file audit procedure on a monthly basis…cases are audited, they're sent to the heads of locality, they have to complete a thematic report about what's going on in their service area – what actions they've taken if they've found it unacceptable, low standard and they also then report that to the strategic leadership team'*

P5. *'I've audited the number of cases, which have been allocated to the teams, to look at how we dealt with most of the referrals'*

Despite these efforts, internal audits persistently reveal issues with documentation, record keeping and other administrative tasks. Participants 2 and 5 outline some of the issues uncovered during internal audits and associate these with a higher risk of inadequate practice. Both participants are open and transparent about the issues at their trusts and ready to take on the challenge.

> P5. *'There were lots of issues about whether things were being kept on files, which they sometimes weren't. There was no paper trail for investigations. There were issues about strategy discussions; there were issues about closing things down from police. So there were a number of issues that really need to be addressed and um I shall be going to managers meetings and highlighting what's going wrong'*

> P2. *'I think sloppy record keeping, where you half complete demographic details, you half complete risk assessments, you don't sign them, you don't date them. You half complete all sorts of bits and pieces, you've got pages falling out of records, you've got out of date care plans, you know this sort of thing. The risk is undoubtedly, no matter what service you're in, so much higher.*

Of further concern is the lack of access to viable benchmarks and comparable data, to measure the standard of adult safeguarding work being undertaken within mental health trusts against other trusts. Participant 5 expresses her frustrations with this, but sees it as *'a job for the boards'.*

P5. *'I also really don't have any point of comparison with any other organisation either so I don't know how we can know whether it's good or bad'*

P5. *'But it's quite difficult to do much kind of statistical benchmarking, because trusts are all different sizes and different staff groups and different ways of organising, so in terms of any kind of effective benchmarking, it's quite difficult to do that. Although I think that's a job for the boards to be doing really. I think they could be doing a bit more to be looking at it!*

A planned development for the purpose of auditing adult safeguarding will involve obtaining feedback from patients and carers regarding the quality of care received. Participants 12 and 13 highlight service user input and feedback for its potential to demonstrate a reduction in the duration of investigations, which may be used as an outcome measure.

P12. *'The questions I want to start asking patients are about fundamentals 'Did your nurse spend time talking to you? Do you understand your care plan?'*

P13. *'In terms of performance management, the information I want to see is timescales of investigations reduced'*

P12. *'We are just about to do an audit of peoples understanding of safeguarding on the back of training because it's my concern about their understanding'*

The audit and monitoring of adult safeguarding practice, as evidenced in this section, indicates that NHS mental health trusts are engaged in activities that prevent abuse and neglect; however, strategic and operational leaders face the challenge of addressing persistent administrative and procedural errors as well as staff adherence to safeguarding processes. Mental health trusts are working towards developing better strategies for the audit and monitoring of adult safeguarding; however, this is notably hampered by a lack of reliable benchmarks with which to gauge improvements in this area.

Care Quality Commission (CQC) Assessments

Participants perceptions of Care Quality Commission (CQC) assessments suggest they should be based upon: evidence of established structures and processes; the existence of an annual report; consideration of the number of cases that involve allegations against staff members or patient-on-patient assault, and evidence of learning from former incidents. Despite this CQC assessments are fallaciously based upon numbers of referrals, as explained by participant 5. Participants 1, 5 and 3 express their disapproval of CQC assessment criteria and propose alternatives that would be more representative of existing practices and arguably more revealing.

> P1: *'So, if I was somebody looking from the outside in, I'd be saying where is your annual report – you know, what structures and healthy things have we got in*

place and what evidence have we got to support that we have used those procedures. So that's where I think we should be judged I think, in terms of how we enact the procedures'

P5: *'I mean the numbers matter, but they shouldn't be worrying about the number of referrals, because actually that's the job of the safeguarding partnerships. The CQC shouldn't worry their heads about it, because that's what they're there for. How many referrals we've got and whether we know the outcomes of them isn't telling them anything about the organisation'*

P3: *'Well I think they should be more concerned with, um, the cases whereby there have been allegations against members of staff or lots of patient on patient assault - they should be concerning themselves about those. That's all they should be really interested in and um how the trust is dealing with them and the lessons they're learning from them'*

CQC assessments are, thus, perceived as a misrepresentation of actual practice. The CQC use data generated by the National Patient Safety Agency (NPSA), National Reporting and Learning System (NRLS) despite flaws with how the data is recorded. Participant 12, an Executive Director of Quality, explains that the NRLS categorises some incidents as abuse, although they may not turn out to be a safeguarding issue. She is clearly incensed by this and recounts how the CQC confronted the trust's safeguarding lead about the figures causing him to become *'really upset'*.

P12. *'Well what happened was on our incident reporting system, people put abuse, it's categorised as abuse and actually, that can be two patients having a fight, it could be attacking a member of staff…it's not always a safeguarding issue and what we were showing on the NRLS is a huge amount of incidents under the abuse category'*

P12. *'Of course, what happened to us in November, we'd had a spate of incidents that we'd reported – five homicides - three of them turned out not to be homicides that were related to patients of ours, two were serious incidents…but they used that in November even though by the time we got to February, that picture had changed radically'*

P12. *'He was really upset, he was really upset because he walked into an interview and they said "oh you've had thousands of this thousand and something abuse"…"well no we've had this many" and not all of them turned out, you know, we've had this many alerts, this many safeguarding incidents reported, and this many that have kind of gone on to then become some massive safeguarding issue'*

In addition, there is a lack of understanding on the part of the CQC surrounding the intended transparency of multi-agency arrangements for reporting and assessment. As participant 13 explains, there were misunderstandings about the requirements of the multi-agency policy.

P13. *'This was one of the issues we had with the CQC because the CQC were almost inferring that we needed to put a system in place where we know all our alerts so that everything came through safeguarding within the trust and we were saying that's not the multi-agency arrangements'*

There are a number of issues with assessments for adult safeguarding carried out by the CQC. The assessments themselves, which are based upon numbers of referrals, contravene the intended transparency of multi-agency imperatives, which encourage trusts to refer openly to ensure issues are not being kept in-house. In addition, multi-agency guidelines stipulate that individual teams submit safeguarding referrals directly to the local authority to ensure the process remains transparent. CQC assessments should thus be adapted to reflect existing multi-agency requirements for adult safeguarding. This could potentially reduce the likelihood that mental health trusts will under-report adult safeguarding incidents to comply with CQC expectations.

Conclusion

The establishment of procedures for adult safeguarding within NHS mental health trusts is evident with trusts introducing dedicated posts and teams and a range of staff training provision. Such steps indicate an emergent safeguarding culture within mental health trusts, albeit on a superficial level. Current training provision is inadequate in terms of the length of time for delivery, the frequency of mandatory training, and the overall impact of training on day-to-day practice. The reporting process is unnecessarily complicated and results in communication breakdown and a lack of ownership between teams and services. The complexity of incidents that occur with mental health clients exacerbates the uncertainty associated with determining when safeguarding intervention is required. In addition, participants highlight flaws with the procedures for internal audit and external assessment; however, this does not ameliorate the lack of referral data received by local authorities and non-adherence with adult safeguarding protocol in mental health.

5.3.2 Challenges to Effective Implementation

Strategic and operational leads for adult safeguarding report multiple challenges with the delivery of effective adult safeguarding practice. Responses in relation to this have been organised into five sub-categories: *the complexities of delivering safeguarding within the context of mental health*; *a prevailing culture of disengagement*; *staff perceptions, attitudes and responses*; *management level barriers*; and *health and social care services.* The fluctuating nature of mental illness and the prevalence of both repeated and unfounded allegations among this client group increase the complexity of decision making for practitioners. Despite this, there is substantial evidence of disengagement and inadequate practice within NHS mental health trusts.

The complexities of delivering safeguarding within the context of mental health

Ethical Dilemmas

There are a number of complexities associated with safeguarding adults with mental health problems that are unique to this client group. Dilemmas occur where patients are both the victim and the perpetrator, which results in ambiguous decision-making trajectories. Participants 4 and 7 outline some of the ambiguities practitioners may be faced with when making decisions about raising referrals. Participant 7, a clinical director with a background in psychiatry, explains the complexities associated with people who are described as *'disturbed'* and detained under the mental health act. He appears to suggest that for this group of service-users incidents are dealt with as part of the day-to-day management of patients and safeguarding is only used when an issue

becomes persistent. This emphasises both the importance of professional judgement, but also raises questions about how thresholds are determined where safeguarding is concerned.

> P4. *'Say for example where you've got two patients on a ward and they thump one another. Now some people might say, oh well they're both vulnerable we've got to raise a referral for both of them. Well if we did that, we'd be doing that all day. But in terms of whether or not, those people are both vulnerable, you know you have that debate'*

> P7. *'When people are detained under the Mental Health Act, it's those areas that are more grey, because someone is being detained they are being looked at, for example if they are in the intensive care unit and people are disturbed, someone assaults someone, how do we safeguard that interest? Because that is done in day-to-day work, in the context of the individual management plan for the patients, but if it becomes persistent, like if relatives exploit money out of them, then we have to use the vulnerable adults policy'*

Similar issues arise where questions regarding patient choice, mental capacity and risk taking are concerned. Practitioners are continually charged with making decisions that achieve a balance between the patient's choice and the duty of care of the organisation. Participant 3 explains the importance of patient choice, but recognises the considerable responsibility on practitioners to ensure that patients are protected. Whereas participant 8, highlights the importance of not becoming risk averse. Both are central to person

centred care provision and highlight the complex nature of decision-making in mental health.

> P3. *'I think there's also the debate about choice – patients having the choice to be and live and do. And of course that's right, people do have choice, but there's something for me about, having an understanding of our duty of care, to people, when they're in our care. And there is a fine balance between choice to live in that way, if we're sure that's their choice, or has their mental illness affected their choice or are they being pressured into living*
>
> P8. *'It's that balance sometimes, because I'm clear that safeguarding is not protecting people from taking risks, it's protecting people from abuse'*

This becomes particularly challenging when service users have the capacity to make their own decisions and they make a choice that increases their risk of being abused, neglected or exploited. Participant 8 explains the emotional impact of situations like these on the practitioner; however, she also highlights concerning issues with the process that may serve to deter practitioners from intervening, which she sympathises with.

P8. '*So if people want to take risks and they harm themselves, that's reasonable and I guess it's that tension that, if something awful happens it's because we haven't protected the individual*'

P8. *'...a woman who had a diagnosis of schizophrenia, but it was well managed and there were no issues in terms of her illness, but she was in a relationship with a guy who was domineering and difficult and they spent their money on all the wrong things and you know it was a volatile relationship…she's somebody who has a mental illness, so technically she meets the definition of a vulnerable adult because she's in a volatile probably abusive relationship, but she's chosen that, she's able to choose that. She spends her whole life going from one difficult relationship to another. And so you can see why people don't put people like that into the vulnerable adult process or investigation because you know, what's it going to achieve'*

The increased ambiguity of decision-making associated with safeguarding adults living with mental illness is particularly challenging for practitioners, as indicated by the above accounts of day-to-day practices. Service-users may be assessed as having capacity and choose to put themselves in abusive situations. Participant responses indicate that existing processes force them to give precedence to a service-user's 'right to choice'. This may result in a lack of intervention when necessary and a dismissive attitude, which will inadvertently increase the risk of abuse going unchecked. It is likely that

practitioners will require specialist skills to deal with the complexity of these decisions within their day-to-day practices.

Mental Illness and Abuse and Neglect: a calamitous relationship

Mental illness and abuse and neglect are negatively interrelated in a number of ways. Participant 8 explains how some individuals suffering from mental illness are undoubtedly vulnerable, as in the case of a *'very unwell'* woman who makes an allegation of serious sexual assault on one of her units. However, she describes others as less vulnerable according to their individual circumstances. In addition, she explains that repeated and often unfounded allegations are common among individuals who suffer from serious mental illness. In response to this, safeguarding is used as an early intervention strategy, for the purpose of promoting a sense of feeling safe among these service users.

> P8.'…*for instance there was an allegation of a serious sexual assault in one of our units from a women* who *is very unwell – you know in the florid paranoid schizophrenic symptoms and isn't in the moment, isn't in the now, doesn't understand what's happening to her now – and that is undoubtedly, completely vulnerable. There's no doubt about it, but there's lots of people in the mental*

health world who are…much more middle-ish aren't they, especially when you bring substance misuse into it'

P8. *'…of course we have some very poorly people there, who will make repeated allegations and accusations. So then we try to use safeguarding as an early intervention measure, if these people feel so unsafe that their not necessarily being malicious, but they're telling you time and time again that they feel unsafe, although the way that they're describing it is not accurate, so we find no evidence of abuse. What we can do is try and work with them to make them feel safer, so they don't feel the need to*.'

The prevalence of repeated allegations in mental health services creates further complications for both the professional and the service user. Although it is common for some mental health service users to make unfounded allegations it is also the time when they are most likely to make a disclosure. Due to the similarities between the symptomologies of abuse and mental illness it is difficult for practitioners to differentiate between the two. This may result in a service user's deteriorating mental health being treated and the possibility of abuse or neglect as the underlying cause of symptoms being overlooked. Participant 15 captures this experience well in her exclamation *'you're damned if you do and you're damned if you don't'* and explanation of the similarities between the symptoms of abuse and mental illness. Participant 3 similarly refers to a practice of *'pathologising'* abuse and the tendency of staff not to investigate.

P15. *'A patient with a mental health problem making disclosure – you're damned if you do and you're damned if you don't, because if you make a disclosure if you're mentally ill, which in my opinion is probably the most likely time when you're going to make a disclosure, because your barriers are down, you're no longer able to protect yourself. If your barriers are down because you're currently mentally unwell, that might be the one time you admit someone has been sexually abusing you'*

P15. *'I think it is particularly difficult in mental health. I think one of the things that comes out in training, one of the exercises that we do is about signs and symptoms of abuse and the signs and symptoms of abuse are exactly the same as the signs and symptoms of mental ill health…but the part that's difficult in mental health is that if they're being abused, their mental health is going to deteriorate, so therefore what they'll do is treat the mental health deterioration, but not actually realise could this be because they are being abused'*

P3. *'For mental health, one of the issues for me has been that mental health has never been a huge performer in terms of investigating abuse. There tends to be a practice of sort of pathologising abuse rather than seeing it as an oppressive practice by someone else, it's seen actually as part of the persons condition, and you end up with all sorts of comments that people make, such as: 'oh well they've made allegations before', 'oh well they've got a history of abuse therefore we have to be careful what they say, oh it's part of their condition and there's a whole range of things like that.'*

Service users who disclose abuse are also at risk of not being believed if their mental health has deteriorated, or if their mental health is stable at the time of disclosure this may jeopardise the possibility of discharge. Participant 15, an adult safeguarding lead in forensic services, candidly describes her views about the reality of abuse disclosures by patients who are unwell. She highlights the ease with which such disclosures can be dismissed as a part of their illness and the difficulty associated with making decisions in her role. Her perceptions are particularly revealing, as they provide evidence of the types of situations that occur in practice whereby mental health practitioners justify not reporting abuse allegations, supporting both the many concerns about the low numbers of referrals generated from within mental health services, but also the alleged dilatory approach to safeguarding adopted.

> P15. *'If you're mentally unwell at that time who's going to take you seriously? They're going to say 'he's mentally unstable, he's talking rubbish'. When you are mentally well, you want people to believe that you are mentally well – you're trying to get out so do you really want to at that point to disclose who's been abusing you. Or if you do, do people start thinking that you're mental health is deteriorating again…therefore it's really easy to target any disclosure as a hallucination or a part of their paranoia. And I find it really difficult sometimes in my role. I stand back I look at an allegation, I look at the patients diagnosis and I*

think oh my god, how do you determine it if you've got no evidence. How do you know? '

This issue is exacerbated in forensic mental health as service users in these settings have committed crime and therefore garner less public sympathy, as explained by participant 15. Indeed public resentment towards those who commit crime may serve as a considerable disadvantage to forensic service users who experience abuse or neglect. Practitioners may also adopt a more punitive approach to safeguarding issues that occur within forensic services due to knowledge of the criminal history of service users.

P15. *'It's forensics so a lot of people have committed crimes therefore they generate very little public sympathy. Our patients have killed people, raped children and so on. Who's actually going to care, well most people are going to say well that's what they deserve. If staff are abusing them or the patients are abusing each other who is going to have any sympathy for them?*

P15. *'A huge issue with forensic mental health is the problem of for example child perpetrators in prisons being preyed upon by other prisoner's it's very difficult to keep them safe. And who's going to care about them. No-one, the public are going to think they got what they deserve'*

P15. *So staff have also got that kind of knowledge…so a lot of patient on patient stuff, whereas perhaps in a residential care home, you might escalate that a bit further where as in forensics, we're down on them like a ton of bricks, but very often the power differentials are about the same'*

There are considerable challenges associated with protecting individuals who are living with serious mental illness that are potentially divergent from the challenges associated with protecting adults at risk in more mainstream NHS services. As is evident within the above discussion, service users may experience discrimination, dismissive attitudes, and unfair treatment at the hands of staff members. Participant 15, in her account of the challenges faced within her role as adult safeguarding lead, reveals worrying views and practices in forensic mental health settings in relation to service users who commit crime. These revelations give legitimate credence for concern about the protection and safety of forensic mental health service users. Practices and attitudes such as these must be challenged vehemently from within these services to ensure that service-users are receiving adequate protection.

A prevailing culture of disengagement

Evidence of disengagement

Multiple factors signify that mental health trusts are disengaged with adult safeguarding. They consistently display a lack of co-operation with local procedures, unwillingness to engage within a multi-agency context, and produce sub-standard work. Participant 3, a local authority adult safeguarding co-ordinator expresses his discontent with the quality of work submitted on behalf of the mental health trust and their reluctance to take part in multi-agency initiatives. In addition, standards of performance at a very basic level are considered acceptable, as indicated by the views of participant 6.

> P3. *'I can give two very recent examples, which I'm very unhappy about – both involved meetings, which I chaired. In one case, a report had to be given verbally because there was no sort of written report. I chaired a strategy meeting and the minutes, were firstly circulated without having been sent to me for checking. I did check the minutes and the quality was absolutely inexorable and sort of ended up having to rewrite the entire minutes of that meeting myself. So there's that sort of level of sloppiness'*

> P3. *'We're setting up the multi-agency strategic safeguarding hub with the police and part of that will involve initial discussion and information sharing with the police. Now, there's an opportunity there for the trust to up its game by putting bodies into that and the trust has said that they don't want to do that'*

P6. *'I mean this is a dreadful thing to say, but if I could trot into work every day and do the very basics of what I need to do to make sure that people's needs are met – and you know, if I didn't flag and push a safeguarding issue, I don't think that would be picked up by anybody'*

Participant 16 further points out that assessments by external agencies in his trust have concluded that procedures are not *'as robust as they should be'* and *'a sense of what safeguarding is about'* is not evident at an organisational level. This has had a negative impact on local agreements with partnership agencies.

P16. *'There was an inspection in December and that really put things on the map, because actually they said 'you're not dealing with this properly' you know 'you've got responsibilities here'. We were managing social workers at the time so that was delegated from the Local Authority (LA)…in terms of adult safeguarding we were not dealing with that. As a result of that inspection, the partnership agreed with the City Council was terminated.*

The evidence offered by participants in this section demonstrates that NHS mental health trusts are not invested in the wider adult safeguarding agenda with regard to process and procedure and indeed the lack of willingness to partake in multi-agency initiatives and tendency to produce sub-standard work will hinder progress. However,

the many examples of indirect disengagement provided by participants that have been discussed in the preceding sections and subsections, indicates a deeper organisational problem. Some of these issues were explored during research interviews and are discussed in subsequent sections.

Historical features that contribute to disengagement

Historical features of mental health services contribute to a culture of disengagement and impede the development of effective adult safeguarding practice and performance. Participant 11, a safeguarding lead and former psychiatric nurse explains, that historically mental health service provision existed in the form of asylums that had a potentially isolating effect. She explains how, despite the fact that many staff members had never been in an asylum, during the early days of her career she found the culture stifling.

> P11. *'I think we were isolated. We had these asylums with great big walls…I mean there's a lot of people working in mental health now who never ever went near one of those big asylums, but I think we had our own walls around, you know "we don't engage with other agencies, we don't do this, we're very secretive, we don't..."Now I don't know if it's because I was not far off thirty when I came into mental health…but I came in and I found it all incestuous. I found it so closed, isolating and I couldn't understand why we weren't working with that agency down the road or you know.'*

Participants 14 and 15 express similar views and suggest that contemporary mental health services continue to display a closed and isolated culture that feigns a notion of superiority that *'you can't seem to crack'*.

> P14. *'I think you could easily say that mental health are one step behind because of their own way of working with issues and I think some protective barriers are there'*
>
> P15. *'I think mental health are just behind, but because they've been accused of being in the wrong, people have become defensive. And that has become a part of the problem'*

This inward looking focus has resulted in a tendency to deal with issues internally using other approaches. Participant 3 describes an approach in mental health that is focused on problem solving, which is echoed by participant 14 who refers to a culture that is focused on managing risk. Participant 14 also proposes that mental health trusts do not want attention on safeguarding, further supporting the existence of an internalised culture.

> P3. '*In mental health, there's a view that things need to problem solved rather than to be investigated as a sort of breach of that person's human rights. And so*

quite often things are not reported to other investigative agencies, because staff feel it's much better, to try and work it through with the individual and that of course just reflects the problem back on to the individual…rather than recognising that the state has a responsibility to support and move it on.'

P14. *'I think in mental health you've got this culture of "we've got this process to deal with and manage the high risk' but if there's an alleged perpetrator, a form of abuse, it should have also been safeguarding…and then do people actually value and appreciate safeguarding because there is the school of thought that the cases that should be safeguarding are not, they're becoming CPA and complex care management because that's happening in older adults services. Or is it that we've got a culture here that doesn't want to highlight the fact that there's safeguarding because they don't want attention on that'*

In some cases, these issues have created a defensive culture where practitioners *'were looking for somebody to blame, and they were very defensive'*, participant 3 explains. Participant 13, an adult safeguarding manager, describes the former culture of her team as '*impenetrable'* where some staff members *'would cover anything up to protect'* the organisation. This *'sort of collusive and internalised'* culture is entirely undesirable and efforts are being made to move towards a more transparent way of working, as explained by participant 5.

P5. *'If things go wrong and you address them in a way that doesn't seek to apportion blame, but seeks to understand what it is about our systems and processes that led to that event, then I think you're being transparent and honest. If you're always brushing it under the carpet and hoping somebody from outside won't look in and see – then it's sort of collusive and internalised'*

Despite concerns about disengagement with adult safeguarding within mental health services there is confidence among operational and strategic leads that staff members generally act in the best interests of their patients. Participant 15 feels confident that staff members want to do a good job and will protect service users when the need arises.

P15. *'Even though people don't get it, the majority of staff come to do a good job and they come to protect their patients. Now they might not always realise that a referral needs to be made and they might not go through the safeguarding process, but most staff will get off their arses and do something. They'll write a care plan or write a risk assessment or get a bullying co-ordinator involved'*

A historically collusive culture reflects poorly on the organisation and is particularly challenging for those who are responsible for the strategic leadership of adult safeguarding. The cultural practices discussed have negatively impacted the

development of effective adult safeguarding practices. Given that such practices, as identified by study participants, are rooted in the legacy of former asylums, cultural change must be a long-term goal. Furthermore, strategies to address cultural issues are likely to require ongoing feedback to staff members who engage in practices that serve to conceal abuse.

Staff perceptions, attitudes, and responses

Challenges at the front-line

From a strategic perspective the greatest challenge is to ensure that adult safeguarding is embedded '*right down to the front-line'*. The penultimate goal for strategic leads is to *'have confidence that our staff do really understand what we're talking about'*, that they understand their roles and responsibilities for adult safeguarding and *'that they have confidence to make referrals'*, participant 7 explains. Nevertheless, engagement at the front-line is commonly identified as a barrier to successful implementation. Participant 5 explains that strategy is rendered ineffective without the buy-in of front-line staff.

> P5. *'People strategically feel empowered they know what it is, but actually, how does it influence what we're doing on the front-line…I think what I've learned about safeguarding is that you can have great strategies, you can have perfect ownership, you can have lots of ambition and drive and people who really want to make it work, it's their passion, but actually it gets stuck at that level'*

Staff attitudes to adult safeguarding are a particular issue. Indeed, staff members often suggest that adult safeguarding is inapplicable within the context of mental health. Participants 10 and 2 describe some of the attitudes of staff members to direct challenges made by safeguarding personnel in relation to identifying safeguarding issues. While participant 12 explains that some nursing staff do not embrace

safeguarding within the remit of their role and as an alternative contact social services for advice.

> P10. *'The biggest challenge was attitude..."well we're an adult trust and we're mental health and learning disabilities and we do that, it's our bread and butter" and what would we possibly need to know'*
>
> P2. '*You'd hear people say that's not a safeguarding issue, that doesn't sound like safeguarding to me. We were actually saying well you know who's to say it isn't? Who are you to say that isn't safeguarding – sort of in a polite way, and actually getting them to think about safeguarding…and you'd put the challenge back to the ward, you'd put the challenge back to the teams and slowly I think, you know, the penny started to drop'*.
>
> P12. '…*"if you went and you felt that there was an issue with a person's finances…well what would you do about that?" I remember using this example on a number of occasions. "Oh, it's not my job" or "Well, it's not our role to do that" but … and probably some of the better answers that I got was "Oh, well I'd ring Social Services'*

Individuals with leadership responsibility for adult safeguarding are engaged in efforts to embed adult safeguarding at the front-line; however staff attitudes in mental health pose a significant barrier. The direct challenges posed by operational and strategic leads are a potential pathway to improvement.

Understanding, recognition and acceptance of responsibility

Understanding, recognition and acceptance of responsibility among staff members, is also particularly challenging. Participant 12, an executive director with board responsibility for safeguarding adults and children, explains that some staff members are burdened by the situations they have to deal with and resultantly may engage in *'avoidance behaviour'*. However, participant 2 believes that staff members are not *'always clear about the procedure and their responsibility'* for adult safeguarding and often fail to recognise the right course of action.

> P12. *'Actually sometimes staff are so overwhelmed with the distress and the difficulties that they're surrounded by or their caseloads that, actually what they get into sometimes is, I'm sure there's a psychological term for it but, is avoidance behaviour. We don't want to ask those questions because…actually "I'm not quite sure how I'll deal with it if I get the answers I don't want to hear" "I might feel overwhelmed, and that", so you start to feel there's a disconnect and I see that quite a lot'*

> P2. *'I still see sometimes...that somebody has picked up something in an assessment and they have informed somebody else within our organisation – and not thinking – actually that's my responsibility. If I've assessed that person…I have that responsibility and it's not okay for me to send that off to somebody else in the department'*

On the other hand staff members may not fully understand what adult safeguarding is, which may also result in a lack of appropriate action being taken. Participant 3, a director of nursing, recalls a report regarding a fire risk associated with a person living alone and confusion about whether to report the issue to safeguarding. She subsequently reflects on the *'lack of understanding about safeguarding'* among staff members at her trust and acknowledges that there is much work to do. While participant 12 highlights that people may not always recognise that they have made an error.

> P12. *'I see often, people say, "oh, we didn't do anything wrong" and when you look at it they didn't do anything wrong, but they didn't do the right thing either'*
>
> P3. *'I'll give you an example. We had a report of someone who was in and out of our services all the time, but lived alone and was in danger of you know setting fire to themselves either because they had a cigarette and fell asleep, or because they put things on the cooker and forget...and there was some confusion as to whether that was a safeguarding issue or not, because a comment I saw in the report was there had been no abuse'*

Of further significance is the perception of participant 10, who believes that some staff members are *'scared'* of safeguarding. She associates some of the disengagement observed at her trust with feeling intimidated about the process and highlights the importance of an open, constructive and supportive learning environment within which

staff members can learn and ask for help. She emphasises the importance of this to maximise the safety of the environment at her trust.

> P10. *'Yes, but people are scared, they're scared of safeguarding. There's something mystical about it and a bit frightening and what we've decided from our forum is, we have every so often, like an action learning part of the meeting, because I want people to come and say, I'm not sure about this, I don't understand this, because if we allow people to do that, we make the organisation safe and we make people safe. Whereas if they don't feel they can come and admit and feel a little bit vulnerable themselves, things could be covered up, practices could be happening that we don't know about.*

Staff understanding and acceptance of responsibility is key to the success of adult safeguarding within mental health trusts. The discussion in this section highlights the need for up-to-date and accurate knowledge and understanding of adult safeguarding and the circumstances that require intervention, to ensure that appropriate action is taken by staff. In addition, it is important that operational and strategic leads recognise the already burdensome nature of practitioner roles in mental health and ensure that processes are clear and accessible to staff members. Furthermore, staff members must be adequately supported to explore their actions in an open and transparent environment that fosters learning and development.

Response to investigations

Safeguarding investigations often leave staff members feeling demoralised particularly if they have been at the centre of an investigation or have witnessed something untoward. Staff members may often respond in a defensive manner, which must be managed sensitively. Participants 1 and 2 discuss the emotional reactions of staff members to investigations and empathise with these experiences.

> P1. *'From our directorate perspective and um you know from speaking to staff, obviously it can feel quite threatening if they've witnessed something or if they're the subject of you know an accusation or anything like that, or um if they're being interviewed it can be quite threatening to them, because it's like you know what do people think of me and do they think that I'm like that, you know what I mean'*
>
> P2. *'You've still got people that feel very sensitive about that, so I would say that there is a great deal of anxiety when it comes to investigations, in particular when they're outside. When they're internal people get twitched, but certainly I think there is less anxiety'*

It is essential from a leadership perspective that staff members are supported to learn and recover from these experiences. Participant 1 emphasises the importance of this particularly where malicious allegations are made. Similarly, participant 2 emphasises the importance of positive communication and putting *'people at ease'*. She recounts

the emotional impact of a suicide case that prompted an investigation and speaks of both the trauma and heartache experienced by staff, as well as general learning.

> P1.*'Where it's been a difficult issue and someone's reported a colleague, or even if someone's reported something maliciously and the safeguarding team thinks there's no substance to this. No one is going to write you a letter and say you're completely exonerated. It just does not happen and so that's the bit I think people find difficult to deal with'*
>
> P2. *'I think we have a responsibility when we're doing investigations to make sure that we're communicating the purpose of the investigation in the most positive way that we can. You know so that you put people at ease. I mean I did a suicide investigation on one of the wards relatively recently and it was very traumatic for everybody. I mean the lady didn't die on the ward, but she died while she was under our care and um people were you know, very, very sad about it…there was some heartache as well as some general learning that needed to take place, but we've dealt with it sensitively.'*

Understandably, the ordeal of a safeguarding investigation results in reduced morale and often times heartache for staff members. If situations like these are not managed correctly staff members may become resentful and demotivated, with the possibility of this further contributing to an internalised defensive culture. Operational and strategic leads are aware of the significant impact of investigations on staff morale and take steps

to ensure that issues are dealt with sensitively and that support is provided for recovery where necessary.

Hard to reach groups

Of all staff groups, doctors are identified as particularly hard to reach with little recognition of the responsibility for adult safeguarding associated with their roles. Participant 2, a service manager and risk co-ordinator, recounts a conversation with a social worker during which she asserted that permission from a consultant was not required to submit a safeguarding referral, as this appeared to be a deterrent. She also identifies consultants as less clear about when safeguarding should be a consideration and tend to rely more on their own expertise.

> P2. *'And we still have those issues even today, where you have to you have to put in those gentle challenges to teams, especially the Doctors I have to say…"I don't think this is a safeguarding issue"…you'd hear them say. And I mean there was one fairly recently over in xxxx and I had a conversation with the social worker and she said that she'd spoken with the team and the team were prepared to put in a referral. So she was asking advice – and I said well you put it in then (laughs)...you know, you don't need their permission'*

P2. *'In terms of the decision making process there may be still some consultants that, if it's overt I think they're fairly clear, but if it's sort of covert and they're not really quite sure or the client has a personality disorder, you know there's this sort of, well we're not sure whether we should believe them sort of thing. And then there are some consultants who I've known, who are extremely open to adult protection issues'*

Participant 16, the head of safeguarding at his trust, also feels strongly that doctors are a problem group. He suggests that doctors are less likely to acknowledge the significance of adult safeguarding and worryingly put the organisation at greatest risk due to a lack of engagement with training, inadequate record keeping and reluctance to share information. More significantly, GPs appear to be the *'group who least get it'* and have to be encouraged to report suspected incidents of abuse.

P16. *'Yes, I think there's still a lot of concerns amongst medical staff, amongst doctors. We'll talk about doctors…I think they are the hardest to reach group because, I don't think they think it's their responsibility. You look at the training records in this Trust the professional group who have had the least safeguarding training is the medics. Those are the group that we're trying to encourage at the moment to do their training…and they are the people who actually, you know, you go into a set of records when something's happened and they're the group actually who I think put the organisation at greatest risk and put themselves at*

greatest risk. Because I think there's still a lot of doctors hung up about information sharing. Who think that either it's not their responsibility or they can't share the information because they're breaching confidentiality and not quite understanding at what point they can breach that confidentiality.'

P16. *'Actually to be very clear, particularly to GP's to say "it's ok to share this information. Please don't worry. If you think that a child is being abused or neglected…please report it, please share it. It's ok - you can do that! You're not going to get struck off…you're not going to get sued or anything". I suppose, to some degree, our consultants we can get onside a little bit easier but you do see out there GP's are actually, "yes, they don't get it".'*

Hard-to-reach groups are inevitable where the implementation of organisational practices and procedures is concerned and participants in this study were cognizant of that fact. However, due to the long-standing power differential between medical, nursing and social care staff, with doctors claiming the highest authority, the revelations in the above discussion present an even greater challenge. Operational and strategic leads are suitably prepared for this challenge; however, better integration of professional groups who are potentially segregated from mainstream services, such as GPs, with trust wide initiatives is required.

Management level barriers

Buy-in at the level of middle-management

Adult safeguarding has not been a priority for middle managers and they appear to be disengaged from the process. The delegation of duties to junior team members and denial of responsibility observed among middle managers is particularly concerning and has significant ramifications for buy-in at the front line. Participants 3 and 6 express similar views about the engagement of middle managers. Participant 3, a local authority adult safeguarding lead, is incensed by the lack of input from middle managers and points out that their inaction is non-compliant with local and national procedures. Participant 6, who works in forensic services, is a little less certain as she feels that some managers are interested, but she senses that improvements are required overall.

> P3. *'If it's not a priority for the managers, then the staff won't see it as their priority either. And the evidence that I've seen in relation to ongoing cases suggests to me that managers are not sort of sufficiently contributing and what we end up with is individual workers running around chasing their tails and being given very little direction.'*

> P3. *'Because the trust knows, as I do that there are some managers within the xxx who are very uncomfortable with this as an area of work, who don't see it as part of their job, who lack confidence to do it and who actually will always delegate it to a junior member of staff and tell them to get on with it. Well that's fine, except that our local procedures and all procedures nationally, require there*

to be some management input into investigations because it involves deployment of staff and also it's an organisational risk.'

P6. *'I don't know what it is really. I think what I would like to see is more of a buy in by the managers within the service. I'm not sure and I'm not saying that they're not going to buy in and they're not interested, because they are interested, but I think that I don't feel that it's as high a priority as other things. Um there's some interest from the service lead...but I'm not getting any input saying well where are you up to with this? Is there anything that we can do? There's nothing like that really'*

The negation of middle managers to engage with adult safeguarding impedes uptake among front-line staff. Both participants 3 and 6 highlight the impact of disengagement at management level upon the performance of teams. In addition, participant 3 points out the difference in the number of referrals submitted by a team with an engaged and pro-active manager in comparison with those who are less so.

P3. *'If you haven't got leadership, then you won't have the performance. If it's not a priority for managers, then the staff won't see it as their priority either'*

P6. *'And the other problem is that if they're not prioritising it then the teams aren't going to prioritise it, because they're not feeding it down either saying you need to be doing this and that. So it is a real battle from the bottom up really'*

P3. *'There's one mental health team...in which they have a team manager who is very committed to this, where you see a lot of referrals in comparison with other teams in the county, where you see minimal'*

Intervention by senior leaders is difficult due to the competing demands of operational and strategic roles. For example, individuals with strategic roles will have a limited knowledge of what goes on at an operational level. Participant 5, a safeguarding consultant who operates at a strategic level, explains how difficult it is to monitor what is going on within the teams and relies upon receiving this information from middle managers.

P5. '*Yeah...unless you're sitting in a team for six months, you can't glean what's going on easily. All you can really do is to be saying to managers, this doesn't look right you need to find out why your team is doing this. You know, and putting it back in the court of the managers to do something about it. Because I don't have an operational role to make it happen - they have to be the ones to make it happen'*

The role of middle managers is pivotal to the successful implementation of adult safeguarding; however leadership at this level is inconsistent and often inadequate. The discussion in this section indicates that adult safeguarding is not a priority for some middle managers, which is having an impact on uptake among front-line staff. A likely consequence of this lack of engagement is the inconsistent performance observed across teams, as discussed. Intervention by more senior managers is required to ensure that all teams function at above an acceptable level of performance.

Engagement at executive level is an issue

Executive directors, despite being perceived as instigators of change and implementation are somewhat detached from the adult safeguarding agenda. Many are ill informed and rely on the expertise of individuals employed within substantive safeguarding roles to inform them about safeguarding. Participant 5, speaking from her position as a safeguarding consultant explains the unique position she finds herself in. She jokes about the fact that she could be telling her senior managers *'a load of rubbish'* and they would never know.

> P5. *'Well it's a funny role to be in, because I'm the expert if you like and so I know more about safeguarding than my managers and that's sort of a strange place to be in, because you know I worked for the Local Authority and your boss is the font of all wisdom, they are the person with the vision about how the*

service should look. Whereas in this role – nobody knows what to ask me unless I tell them'

P5. *'In terms of, you know, what safeguarding is all about and you know what's important, it's down to me to tell them, not the other way round. So, that's fine, because that's why I'm here I suppose. But I suppose I could be telling them a load of rubbish and I don't think that they would know!'*

In one trust the executive team failed to recognise the opportunity to learn from *'what patients, carers and staff were saying...when things had gone wrong'* in other settings and how this *'related to a mental health trust'*. Participant 3, an executive director of nursing, describes how ashamed she felt when she delivered a presentation outlining lessons to be learned from 'Francis', but her colleagues failed to see the relevance.

P3. *'The Francis Inquiry was released in the February (2013) and I did a presentation to some of what we're calling our executive leadership council: general managers, clinical directors, associate directors. Now some people you could see totally got this and totally understood why we were saying these sorts of things, but others came up to me afterwards and said, but that was acute trusts...they just couldn't see the connection'*

P3. *'I've been in the NHS since I was sixteen and I love the NHS, but when I did this presentation to this leadership team on Francis, I was so emotional and*

upset. I was ashamed of the NHS and ashamed of my profession for the first time in my life'

Executive directors are also highlighted for considerable oversight to the need for safeguarding intervention. During a research interview, participant 12 described an incident involving a local business-man, who invited some young men who were addicted to heroin, with complicated mental health issues, into his home to make a documentary film about their journey to recovery. There had been numerous contacts with the trust regarding the behaviour of these young men, which was becoming increasingly aggressive. Despite advice to raise this as a safeguarding issue no action had been taken. She perceived this as a blithe disregard for expert advice in favour of receiving public recognition for the trust, as she explains below.

P12. *'So he's a director, there's a whole line of management underneath, none of them had considered safeguarding. We have this conversation and in the end, I had to say "no safeguarding, I want you to raise an alert". A week later, they still haven't done it because they didn't really want to do what I was asking them to do and then start to say "oh we didn't think it was that serious"'*

P12. *'My take on it was that it was the ego of a man who owns a local television company, filming some people getting better off heroin and that we might attract some publicity around that for said lead people clinicians'*

She further highlights the impact of the local political agenda on the priority given to adult safeguarding. For instance, in her locality safeguarding children was politically more prominent due to negative national attention on high profile child abuse cases, which *'is perhaps why adult safeguarding is sort of undermined'*. She explains that initiatives that are perceived as politically more important receive greater attention, which she associates with some *'peoples jobs'* being prioritised and the influence of *'elected members of councils'*.

P12. *'I think xxxx is quite a political area. If it's not high up on somebody's agenda, politically there's not necessarily the attention paid to it that it might require. So for instance, politically, (the local) safeguarding children's board has really sort of hogged the limelight because it had sequentially been judged as being inadequate in the way that it, you know, the safeguarding arrangements for children in xxxx. So that, politically, is very high up the agenda, so I think that kind of overshadows – perhaps why adult safeguarding is sort of undermined.'*

P12. *'I do think that it's political 'cause it's about …it's about jobs, people's jobs and it's about elected members of councils and, you know, and all of that and I*

do think there's without doubt an element of that. I'm not trying to send some sinister message, you know, but I'm being really straight with you.'

Executive leadership is consistently highlighted as an indicator of success, particularly in relation to the implementation of newly developed policy and practice initiatives. The experiences of participants highlights that the trusts in this sample have passionate executive leads for adult safeguarding, but wider executive level support is considerably inconsistent. The discussion in this section highlights the failure of some executive leaders to recognise the strategic importance of adult safeguarding; however, this is a considerably complex issue that in some cases is interwoven with the political motives of individuals and wider geographical areas.

Health and Social Care services

Integration vs. Segregation

The integration of health and social care services can have both a positive and negative impact on adult safeguarding practice. For example, within integrated teams where experienced social workers and clinicians work side-by-side, operational and strategic leads for adult safeguarding have confidence that adult safeguarding issues will be dealt with appropriately due to having knowledge of processes and procedures. Participant 12, an executive director with strategic responsibility, suggests that to revert back to segregated service provision is a *'huge step backwards'* due to the need for *'multi-disciplinary input and where you've got only nurses or doctors...you haven't got that challenge'*. Strategic leads for adult safeguarding with a social care background are also highlighted for their passion and dedication to the cause. Participant 2 highlights the benefits of integrated teams, while participant 3 praises the associate director of social care for her passion for safeguarding.

> P2. *'I mean there are some that I would say are fantastic and there are certainly clear advantages. And I think without a doubt in terms of adult safeguarding, teams that have that privilege of social care on site, either in an integrated or very close partnership working, undoubtedly I think adult safeguarding practice is improved and helped'*

P3. *'I've got a fantastic, Associate Director of Social Care, as well as safeguarding and she's passionate, she's a social worker by background. And she can ask awkward questions and poke and prod, which is excellent'*

Nevertheless, some participants are averse to the idea of integrated services. Participant 2 asserts that while *'the whole idea of integrated mental health services makes perfect sense, you know from the service user perspective',* the integration of *'two huge monolithic institutions'* is idealistic and potentially unattainable. Issues are identified with the use of separate systems, communication, and the appropriateness of social workers being managed by NHS trusts. Participant 2, a service manager with a nursing background, feels that the integration of the services results in a disjointed process and is clearly frustrated by this. On the other hand, participant 6 who has a social work background emphasises the general discontentment of social workers about being line managed by nurses.

P2. *'They've got their system and they've abdicated their responsibility for younger adults' mental health, but you know, we're trying to move on this ageless service and they've got the over 65 service and you know it's just too disjointed. Either give us the social workers and we'll just deal with the lot or let's all have a joined system.'*

P2. *'I don't think that the systems and processes that we've got actually allow that good communication and of course, if you asked a social worker in the*

district team, who else needed to know about your safeguarding issue...you know, they wouldn't think, oh right the risk co-ordinator in the mental health division'

P6. *'And I think, and it's only anecdotal, but in the informal discussions I have with social workers of CMHTs in the trust, is that the general feeling is that people aren't happy with how they're managed. And you know I think even if you look at the background of most managers at CMHT level or for example in the prison-in-reach services, for the vast majority it's nursing. How's that going to work?'*

Within integrated health and social care teams there is also a risk that safeguarding is viewed as a social work endeavour resulting in healthcare staff failing to take ownership. Participants 4 and 15 similarly assert that safeguarding is everybody's business and not the sole responsibility of social workers. Participant 4 believes that these assumptions stem from the former organisation of health and social care teams. She emphasises that safeguarding should be viewed as a *'clinician role'* whilst also recognising that social workers have a specific role to play with certain categories of abuse.

P15. *'The other thing the NHS seem to do is, "oh well it's safeguarding, so it's social care" well it's not, safeguarding is everybody's responsibility'*

P4. *'Well, I think you know historically social workers have been managed differently, but now they are managed as part of the trust. But not in xxxx they are still managed as part of the local authority. So the historic issue is, not to see it as a social worker role, it's a clinician role and not a social workers role. Although they have a specific role to play in terms of if someone is being financially abused and stuff like that'*

This issue may be further exacerbated by the perception of some social workers that their area of work is devalued within a multi-disciplinary context. Participant 6 describes the lack of recognition of the role of the social worker within her service. She intimates that the inclusion of a social worker in her team was a tokenistic gesture to give the appearance of a multi-disciplinary set up. Furthermore, she experiences less autonomy and recognition, as an *'individual professional',* within the hierarchical structures of the NHS.

P6. *'And you know, I don't think social work in our service, is given any real degree of standing or recognition. I think that it's probably fair to say that when the team was set up, it was set up as a nursing service. They wanted to replicate CMHT, so they wanted an OT and they wanted a psychologist and they wanted a social worker, but I don't think they really knew what a social worker did'*

P6. *'I think a big part of it is about the NHS is much more hierarchical. Of course there are hierarchies within the county council and the social work teams, um but*

it's not anywhere near as apparent and it's much easier to challenge in the county council. You know to get your point across, as an individual professional - you've got a little bit more power than you have in an NHS Trust. It's massively hierarchical and of course social work is right at the bottom.'

Participants with strategic level responsibility recognise the considerable benefits of integrated health and social care teams and greatly value the adult safeguarding expertise that social care staff bring. Participants with operational level responsibility also recognise the value of social care input, albeit they naturally highlight some of the practical challenges associated with managing integrated teams. The revelations of operational staff with a social care background highlight discontentment and competing objectives of health and social care that likely penetrates to the front-line. Although efforts are made to improve the circumstances of collaborative working between health and social care services, conflict remains. The significance of this for adult safeguarding is almost certainly negative, but the long-term impact is as yet, unknown.

Differing Philosophical Approaches

The differing philosophical approaches of health and social care disciplines are of considerable consequence to the harmonious integration of services. Participant 13, a local authority representative with a background in social care explains that, *'the health approach to things'* tends to focus on *'whether there's a bar chart to demonstrate that actions have been met'* or that boxes have been ticked. Whereas, a social care

approach, on the other hand, is *'a bit of a jumble actually'* but safeguarding is a fundamental feature of practice. Participant 5 captures this well in her below statement. Participant 15 also emphasises the difference in the language used between the two disciplines.

> P5. *'Well, when you're working in health, safeguarding anybody is part of your job, but it's not the whole of your job, whereas when you work in social care, safeguarding is everything'*

> P15. *'I think the language barrier is a huge one. When they talk about safeguarding they mean something different to when social care are talking about safeguarding and vice versa. Because they talk in medical terms, I think and that will take them a long time to get out of. They just don't understand safeguarding.'*

Perhaps of greater significance is the predominant focus on the individual within the discipline of social care, in contrast with the disease model adopted by NHS services. Participant 12 explains this emphasis well, highlighting a focus on the individual and not the illness and thinking about the patient *'holistically'.*

> P12. *'There are things that are more fundamental than just talking to people about safeguarding here, which is about seeing people as individuals and seeing*

the individual not the illness. And if you start to get over those sorts of barriers then actually people will start to think about safeguarding'

P12. *'If they're not asking the right questions, they're never going to be able to tease out those sorts of things because of the shame, the guilt. So I think that if we started to think about patients instead of illness and think about them holistically then I think that would go a long way.*

Indeed, medical model dominance results in safeguarding being viewed as an '*add on',* to existing roles and not given the priority it deserves. Participants 6 gives her perspective of the difference in how safeguarding is viewed having come from a county council background into the NHS, emphasising that it is not fully embedded. Participant 12, an executive director whose previous experience involved working on adult safeguarding boards within her locality, describes the resistance she is faced with when trying to focus on aspects of care that are not medically based.

P6. *'I think I have different experiences, coming from the Council into an NHS trust, which is very medically model dominated...so it's sort of a bit of an optional extra, that okay perhaps we could think about that, but I don't feel that it's necessarily fully embedded within the team and the service as a big issue and an area that we should be addressing on a day-to-day basis'*

P12. *'There were lots of pieces of evidence that correlated that told me that this organisation is very medically dominated and biologically focused. So what you hear is lots of people talking about assessment, diagnosis, and treatment. What I didn't get a big sense of was how we were looking at people holistically"*

P12. *'Well given the amount of resistance that I have in trying to get things done here that's not about diagnosis or medication. People are really happy when I want to look at medication errors of nurses; people get really excited about that, but when I want to talk about compassionate care...not interested, we can't measure it'*

In response to the identified issues with the successful integration of health and social care services some participants advocate permanent segregation as a viable solution. Participant 6 advocates reverting back to a previous way of working that recognises the *'key differences'* within the disciplines. Participant 2 on the other hand is concerned with the practicalities of managing adult safeguarding with both *'systems'* operating side-by-side.

P6. *'I think, personally, that the sooner we could get back to our respective organisations the better. There are just such key differences that I just don't think they can be managed by an organisation like the NHS where the focus is completely different'*

P2. *'I think if we were to have the resource within the CMHT to deal with all safeguarding issues within the community teams. Um, whether someone is an older adult or a younger adult that would make, because then we could just work within our own...that would be the easiest way'*

P2. *'I think the challenge has always been and will probably always be the two systems trying to operate together, in terms of social care and health.'*

The markedly differing philosophical approaches to practice within health and social care services, is particularly difficult to reconcile within the context of adult safeguarding. The discussion in this section highlights the difference between the priority given to holistic care by social care practitioners and the focus upon on diagnosis and treatment in the NHS. Resistance is evident on both sides and while the points raised are significant, questions remain about the use of resolution-focused strategies and the positive impact these might have. This highlights a potential flaw in the strategic approach to integrating health and social care services that will undoubtedly have negative consequences for the multi-agency provision of adult safeguarding.

Conclusion

There are circumstances specific to service delivery in mental health settings that compound the difficulty of establishing effective safeguarding practice. Mental illness increases the likelihood that allegations are repeated or unfounded and difficult to substantiate; however, substantial evidence of disengagement within mental health services exists. Performance and co-operation with partnership agencies is poor, this is most likely a by-product of a historically internalised culture that negatively impacts partnership engagement. The most commonly identified barriers are associated with staff members, indeed issues are highlighted with engagement at the front-line all the way up to the executive team level. Among staff groups doctors / consultants are identified as the most inaccessible. Disengagement at the front-line is intensified in situations where unsupportive middle managers adopt a nonchalant attitude to their safeguarding responsibilities, which further impedes uptake. Social care has a tangible positive influence on adult safeguarding practice; however there are a number of challenges associated with providing integrated services. There is a tendency of healthcare staff to view safeguarding as a social care endeavour as well as fundamental differences between the philosophical approaches of both disciplines that impact harmonious integration.

5.3.3 Transition to a Progressive Future

The safeguarding culture in mental health was perceived to be transitioning towards a more progressive future. Responses related to this have been organised across three subcategories: *then and now; promoting cultural change*; *leadership*; and *strategies for improvement*. There has been substantial strategic input to promote this cultural shift with recent changes in the attitudes of staff members observed and improved engagement with external partners. Despite these notable achievements, leaders of adult safeguarding face persistent challenges in their quest for change.

Then and now: promoting cultural change

Former Safeguarding Culture

During the initial stages of implementation evidence of a safeguarding culture within NHS mental health services was considerably lacking. Participant 10 explains that *'it was there somewhere in the midst, it was mentioned every now and again, but it really wasn't'* a priority. Safeguarding was generally viewed as *'somebody else's business'* with a lack of appreciation for what it actually meant. Participant 12 suggests they began from a position of complacency, while participant 2 explains what it was like when she took on the role of risk co-ordinator at her trust.

P12. *'There's a sort of complacency that was here in this organisation around safeguarding. Yes, so that was the starting point really, which I felt was below baseline'*

P2. *'When I first came there were a lot of conversations being had within the trust, as to how much the trust needed to improve on its safeguarding processes. They didn't have safeguarding leads…we had champions if you like.'*

P3. *'Again it goes back to that lack of understanding of safeguarding and it's always somebody else's and often they felt that the safeguarding team were imposing an action plan on them, because they didn't engage in getting part of it, because they saw it as safeguarding business'*

Conversations about the need to *'improve safeguarding processes'* were ongoing; however, as participant 3 explains an overarching culture of safeguarding was absent at that time. This was compounded by a reactive work ethic whereby cases were dealt with on an individual basis. Participants 2 and 11 elaborate on the lack of ownership of adult safeguarding within their trusts and the impact of this. Participant 11 appears to indicate a negligent attitude towards the safety of patients potentially at risk of death and a failure to recognise the links between domestic violence and women's mental health.

P3. *'And I think what we were doing at the time, was we were dealing with individual cases of safeguarding and then poof it's gone. We've dealt with that one and we're waiting for the next one, rather than having some sort of overarching strategy, overarching culture of safeguarding is at the heart of everything we do all the time.'*

P2. *'And you'd look back and you do an actual audit, you see there were five disclosures to different people in different places and nobody owned it and nobody thought it was their remit'*

P11. *'…it was like 'well we don't do domestic violence, we do mental health', it was that clear separation 'it's got nothing to do with us". So if a woman comes to see us or we see someone in A&E and we're doing a crisis assessment and she (patient) talks about domestic violence, we go, okay, that's that, she hasn't got a mental illness so we'll send her back to the GP. So there was no understanding of risk and it didn't matter if she went home then and got killed or that her whole mental persona was being destroyed by her domestic violence'*

In time, staff members were beginning to view safeguarding more positively and work in an increasingly transparent manner. Improvements to partnership working with a *'greater degree of openness and transparency'* were observed over a period of eighteen months, participant 13 explains. This resulted in trusts being viewed as *'a strong committed partner by the local authorities'*. Participants 3, 15 and 14 explain how the general overall commitment to safeguarding practice has improved at their trusts,

associated with; new leadership, the altered mindset of staff members regarding the intended strategic purpose of adult safeguarding, and improvements to staff attitudes. In addition, participant 11 highlights an increase in telephone queries regarding safeguarding matters, with participant 14 discussing a slight increase in referrals and improved engagement with the overall process.

P3. *'Over the last year we've gone from that sort of attitude that safeguarding is somebody else's business, to actually it's my business whether or not I'm on the front-line'*

P15. *'Staff are starting to see safeguarding as a positive thing. It used to be seen as another stick to beat staff with. And that's a real common misunderstanding I think'*

P14. *'…you have different people in the driving seat of Safeguarding so you've got rid of old thinking, you know, like "oh it's not really safeguarding, don't worry about it'*

P11. *'We are constantly on the phone. I can show you a folder that's like oozing now from probably the last twelve months, of telephone queries…I mean we're getting huge compliments from people around the usefulness of the support we've given teams'*

P14. '*We've started to address the issue about information sharing on what safeguarding procedure there is…That then has led to a slight increase in mental*

health referrals, so we have seen that happen and that they're following the stages as well now. So they're not just leaving a referral or strategy, they're going from investigation to case conference, but you're still looking at very minimal figures in comparison to other groups'

Despite these observed improvements, participants 15 and 12 indicate that resistance still remains prevalent among some staff members, particularly in those who are *'still engrained in the old ways'*. The introduction of new team members, however, was beginning to eradicate traditional views and attitudes.

P15. *'It's certainly a lot better than it used to be, but there will always be that minority of people, especially perhaps those that have been there a long time, and they're still engrained in old ways. The more new staff we get come in, the better.'*

P12. *'I couldn't say "oh yes I know that we've made a massive impact" because I think the baseline was so low. There is, you know, it pains me to say it even two years in, there's an arrogance about what people think they are here to do. So it's that "Well it's not my role". There is a lot of that.'*

The discussion in this section indicates that during the earliest stages of implementation, adult safeguarding was met with considerable resistance on the part of staff members. Strategic and operational personnel were faced with significant challenges, many of which were related to the inherited culture in mental health rooted in its historic traditions. A degree of resistance is expected with any implementation strategy; however, the suspicion and arrogance of staff members in mental health regarding their level of expertise and standard of practice made for a particularly challenging experience. The nature of adult safeguarding work and the need for transparency further enhanced these challenges. Nevertheless, over a two-year period participants have observed improvements and positive changes in many areas.

Facilitators of Cultural Change

Factors identified as having influenced a cultural shift include: national scandals; the promotion of discussion and learning from high profile cases within the organisation; increased scrutiny from external assessment bodies; and the commissioning of specialist consultants. Indeed, participants 1, 3 and 13 discuss local and national scandals that received attention at their trusts and prompted action on behalf of CQCs and consideration at executive board meetings and staff meetings. In addition, participant 13 highlights the benefits of commissioning an external consultant.

> P1. *'Different high profile things like Rampton and Elly hospital…they really did start to change the way people do things…several other things…Cornwall,*

Sutton & Merton and now the Bristol thing is a reminder that you can never be complacent'

P1. *'So what we ask is that people discuss this at staff meetings and they do because the media is you know a very powerful tool and you know with the thing in Bristol, we have to ask the question with staff, could this happen here…because it could happen anywhere'*

P3. *'Over the last year since we've had the Francis (Inquiry) report and all around Mid-Staffs, we've had the ombudsman report, we've had some of the CQC (Care Quality Commission) stuff coming in, we've now had the panorama programme and that was all about adults'*

P13. *'I would say that the CQC, have locally and probably nationally as well, um feel very conscious of their position now. They've not really, kind of altered their thresholds, but they are combing over places'*

P13. *'So I think that inward looking silo focus has shifted…we commissioned an external consultant to do some work and having that objective view on your service and challenge has certainly really helped my work and the healthcare trust as well'*

In addition to these external factors, long-standing relationships between partnership agencies in certain geographical areas have positively impacted safeguarding practice. Participant 13, who had been working for the council for many years in a variety of

roles, describes how *'faces stay'* and the impact this has on practice. She further describes how such familiarity manifests itself and contrasts this with other areas where strong links are not evident.

> P13. *'And I think there's something very unique to this trust…faces stay and that's just the absolute thing, I mean some people go into work and go, oh no I'm here again and somebody said to me the other day "oh you don't want to be here Jenny, and I said no, the day that I don't want to be here, is the day that I will be going"…so people stay despite the challenges. We've had agency people come at a senior level and they've ended up applying for permanent posts. So there's something about it. It's disorganised, it's chaotic, reactive, but there's some passion here I think'*

> P13. *'It isn't rocket science. I suppose, maybe one factor really is that it's a very small authority, so people know my face - I know theirs. Or if I don't know I'll soon find out who - if there's a new kid on the block. I think for me I would say that the provider arm of the PCT (Primary Care Trust) has a different culture. Probably because it's very inward looking as opposed to…yeah I have strong links with the exception of the PCT'*

This highlights the potential for success within multi-agency partnerships where strong links are established and positive interactions are nurtured within a joint working capacity.

Leadership

Leadership Challenges and Approaches

The progressive development of adult safeguarding is contingent upon strong and effective leadership. Senior leaders for adult safeguarding advocate the importance of strong leadership for the future of adult safeguarding and adopting a more holistic approach that incorporates the 'think family' agenda. Despite such sentiments, senior leaders face many professional and personal challenges within their roles. Challenges for individuals who have strategic responsibility for adult safeguarding include being inexperienced with the organisation as a whole or with some of the specific services in which they have oversight responsibility. Participant 5, who was a social worker by profession, describes the challenges she faced having strategic responsibility for high secure units with very little experience of the area. Participant 13 similarly highlights the benefits of having experience of the organisation and uses the example of a colleague who came from an external service.

> P5. *'One of the problems I had for a while, is I probably worked in every area of the trust as a practitioner, but never worked in high secure – so then to be at a very strategic leadership level and never having actually done the work. I'm not saying you have to, but I think…it helps you understand where the services are at'*

> P13. *'Well I suppose I don't know how somebody could do this job, without having worked for the organisation before. And that might be a factor about that*

person who's been appointed in the (specified team), because he came from external. You see I know how to approach an issue if I've got a meeting with a person and I've worked with them fifteen years ago and knew they were crap. You know…there's something about being fresh, but there's also something about having that institutional knowledge'

In addition, senior leaders experience feelings of isolation within their role and are held accountable for mishaps which increases their motivation to ensure safeguarding is embedded. Participant 5 describes feeling isolated and as though she is always the bearer of bad news, but she understands that this is a part of her role. Participant 12 discusses being accountable when things go wrong, but similarly acknowledges that this is *'par for the course'*.

P5. *'I think we'd all say from time to time we feel very isolated. You're never dealing with simple, straightforward cases because the nature of your job is that you're at the hard end. And I guess the nature of my job is to help the organisation be held to account. So that's the constant challenge and trying to constantly move that on. I don't think I'm always seen as the bad guy, but I think I'm always seen as, um, I suppose I always arrive during the bad news stories not the good news stories'*

P12. *'I certainly feel that if something seriously goes wrong with safeguarding questions would be asked of me and I think it's just 'par for the course'. I think it's*

inherent in my job, obviously being the Director with the accountability at Board for it – I take that very seriously. So of course, what's key for me is making sure that we have got safeguarding'

Senior leaders who are at the forefront of implementation, experience similar challenges with regard to safeguarding and address these in similar ways. It is common for strategic leads to adopt various leadership styles when implementing practice and policy. Practitioners describe having to adapt their leadership strategies to the goals of individual tasks and the challenges associated with different staff groups. For example, participant 13 uses vivid terms to express the different approaches she has to adopt if there are *'funny goings on'.*

P13. '*And the thing I suppose is, I know when to have the velvet glove but I also know when to have the iron fist, so I know when to escalate if we're having some funny goings on. You know, I've had challenging conversations with some mental health managers, because I've said you will investigate this because it's come back to me and you NFAd (no further action) it and you need to go and investigate it'*

The urgency associated with adult safeguarding and inadequate responses from staff members frequently leads to direct challenges from strategic and operational leads.

Where necessary strategic leads assert their authority and affirm that they are *'not afraid to pull their sleeves up'*. Participants 13 and 12 give examples of when it is necessary to adopt such strategies. Participant 12 describes being frank and insistent that an alert was raised when members of her executive team were dragging their feet with a safeguarding issue.

> P13. *'There's a case that ended up in a complaint on a learning disability locked ward recently. So it was wider than safeguarding it was also about Deprivation of Liberty, you know, that wasn't something to resolve in a touchy feely discussion. I want the director of that service in the healthcare trust to provide a quality assurance report…a report was presented and we've sent it back and said it doesn't meet our terms of reference. So we know when to escalate appropriately, you know, resolve if we can, but if we're saying there's something wider than just an individual issue and we want assurance that they're delivering a good service, go do it'*
>
> P12. *'So in the end I had to say no, safeguarding, I want you to raise an alert. And a week later they still haven't done it because they didn't really want to do what I was asking them to do…so obviously, eventually I had to put a bit of a bomb up some peoples backsides'*
>
> P12. *'So they're not getting the challenge. I mean, I think Frank who raised it, rues the day that he ever raised it because we had some very difficult*

conversations about it. Which was about, which part of "contact adult safeguarding immediately" do you not understand?'

Nevertheless, individuals with responsibility for strategic leadership recognise the need to take a more facilitative approach if required. In particular, where learning from mistakes or whistle blowing incidents are concerned, interactions with staff members are more nurturing and supportive. For example, participant 2 describes some of the strategies she uses to facilitate learning through reflection and emphasises the importance of being responsive yet sensitive when staff members raise concerns.

P12. *'So what I've said to Andrew is that I want all of the people that were involved in that, I want a kind of, almost like a…not a blame but to talk through and do it in a kind of reflective way. Their thought processes for why we got to that situation and why it had gone on so long'*

P2. *'Yeah I mean we've had a couple of whistle blowing incidents where people have said, I was unhappy about this or that. And I think the first thing to do as a management team is to respond to it absolutely straight away…you know is to be swift and to believe them and to investigate it openly and to say, you know, that we will do that. So yeah I think it's very important to be responsive and do it with a degree of sensitivity, because you're left with the fall out.'*

It is the ultimate aim of senior leaders for adult safeguarding to increase safeguarding activity to promote a transparent and healthy culture. Their greatest ambition is to ensure that safeguarding is embedded *'in its widest sense'* and that it is fully understood and at the heart of everyday practice. Participant 3 emphasises the importance of taking action, while participant 1 advocates transparency at all costs.

> P3. *'And my philosophy is, you know I think the staff get sick of me saying it, and I've said it in my previous organisations, I will stand up in any court and defend why we did something, but I can't defend why we didn't'*
>
> P1. *'We make a lot of contact and we make no kind of apologies for that because we think that's the way it should be, a lot of the time it might not be, but it gets people used to going through procedures and checking out and that's what helps to keep it safe'*

The discussion in this section highlights the commitment and dedication of strategic and operational leaders to the development of effective adult safeguarding practice. They face numerous challenges including difficult encounters with staff members and executive teams alongside the more personal challenges associated with what is at times an isolating role. Nevertheless, leaders are willing to adapt and develop their skills to ensure they respond appropriately to the needs of staff members whilst promoting a healthy safeguarding culture.

Strategies for improvement

Devolving Responsibilities

A range of strategies are utilised to work towards achieving a healthy and transparent culture. Participant 12 describes how layers of management were being devolved in her trust for the purpose of implementing a transformational leadership approach across the organisation. This was a significant part of her strategic role.

> P12. *'We've just been through quite a significant structural change and I've had to actually put in place a nursing structure. This organisation was quite general management focused – it's very transactional, control and command…and that's part of the reason why I'm here, part of the response to Francis, we were brought in to start to think about how, not think but do…transformational change, devolving responsibilities, empowering people at the front line'*

Improving Multi-Agency Engagement

Some trusts were focused on improving multi-agency engagement as this is identified as a problem area. Participant 2 discusses the need for a county safeguarding establishment with representation from within all partnership services, an approach that is now adopted nationally in the form of multi-agency safeguarding hubs (MASH). Participant 1 similarly emphasises the importance of inter-agency investigations and

representation on safeguarding hubs, while participant 6 highlights the importance of establishing links with the council.

P2. *'I'd almost like to see a county safeguarding establishment, where you've got things like the MARAC (multi-agency risk assessment conference), child protection and adult protection…all sitting under the same roof. You know, we have these conversations in 136[25] meetings…and we often say, if ever there was a need for a multi-agency response team, so you've got police, out-of-house social work, crisis team, and if they're not able to co-locate, they can actually be talking, and I almost think they need something like that for safeguarding really'*

P1. *'And I think that's the healthiest thing that could possibly happen, is that all agencies have a contribution to that and all agencies have representatives on the wider forums. You do need a core of people…something like safeguarding is investigated on an inter-agency basis and that's what makes it safe, because it's inter-agency'*

P6. *'The main thing I try to do, I suppose from a more strategic point of view is make the links with the safeguarding lead in the local County Council. And I've established quite good relationships with them and invited them into a number of meetings over a period of time to discuss how we can raise the profile and how we can look at tackling…the safeguarding agenda'*

[25] The section of the Mental Health Act (1983) through which police are required to keep a person safe whom they suspect is unwell with mental illness

Recruitment Strategies

The improvement of recruitment processes and procedures is also central to the improvement strategies adopted by trusts. Participant 1 explains that while recruitment processes provide an element of safety, unsavoury characters will still slip through the net. In addition, participant 2 highlights the importance of maintaining a *'critical gaze'* where investigations are concerned and ensuring that vigilance is maintained when examining the evidence.

> *P1. 'The only thing I would say is that, you know an interview doesn't necessarily identify the people that you need not have in the service, you can only do so much. The CRB check will tell you that there's no criminal record, or the vetting and barring, you know you do enhanced checks. So that's a structure that makes it safer but not fool proof'.*
>
> P2. *'I mean no one's got three hundred and sixty degree vision, but when you're with somebody and this comes out of the serious incident investigations all the time, that it's so important to have a critical gaze and sometimes don't take things at face value. You know, look for whatever is going on beneath the surface. And if you think of child and adult protection issues, it's not always the obvious that we should be looking for – it is what is not obvious'*

A further strategy adopted by trusts to enhance the safety of recruitment processes is to involve service-users and carers in interviews. Due to having a lived experience of the services, service-users and carers will more readily identify interpersonal characteristics that may compromise the care received by patients. Participants 1 and 3 explain the importance of involving service users in the recruitment process, while participant 3 gives example of the types of feedback given by service-users who sit on interview panels and the characteristics they look for in candidates.

P1. *'…the service-users will say "they didn't look me in the eye' or 'I wasn't happy that when I wake up in the night and asked for a cup of tea and they told me to wait for two hours, I wouldn't be happy about that". The service users are looking for the humanistic…does this person even speak to me in a way that is even attempting to speak in a way that I can understand'*

P3. *'We've got a fantastic involvement team…some of them are employed and some of our staff do it, but actually on the whole it's patients, carers, service users, who are a part of that. We're doing some interviews today for a post, there's a panel of patients and carers interviewing for the candidates job. So we need to get them more engaged in some of the work, we're doing…'*

Conclusion

There is evidence of a cultural shift with regard to adult safeguarding in NHS mental health services. The former complacency that existed is steadily dispersing, staff members are observably more positive, and perceptions of trusts by external partners are improving. Both public and media attention on the issue of adult abuse and valiant efforts to raise the profile of adult safeguarding from within organisations have considerably influenced this cultural change. Strategic and operational leaders, who are at the forefront of progressive development, demonstrate strong leadership, passion for the cause, and unabated commitment to embed adult safeguarding at the core of their respective organisations. Nevertheless, personal and professional leadership challenges continue to exist and numbers of referrals for mental health remain comparatively low.

Chapter Six: Literature Review

Chapter Overview

The following chapter presents the findings of a realist review of literature undertaken to identify factors that facilitate the effective implementation of adult safeguarding in NHS health services. The chapter begins with an introduction to realist synthesis, establishing justification for its application in the present review. This is followed by an overview of the method used, including the various stages and activities involved in completion of a realist synthesis, and discussion of the *Initial Programme Theory*, a core element of realist reviews. The chapter continues with presentation of systematic searches for literature and discussion of the method of data extraction. This is followed by a narrative discussion of the review findings presented across six themes. The chapter concludes with some key observations and recommendations for practice development.

6.1 Introduction and Background

Emergent concerns regarding the disengagement of mental health services from the national adult safeguarding agenda (DH, 2009) prompted the initiation of the present research. A preliminary search for literature revealed a paucity of empirical studies that focused specifically on adult safeguarding in mental health. A discussion of the literature identified, presented in Chapter 1, indicates that issues such as a translational gap between policy and practice, social inequalities, stigmatisation of mental illness, and inappropriate responses to allegations of abuse, were contributing to the disengagement observed in mental health services. During the early stages of this research, consultation of a broader literature revealed an emerging evidence base for the establishment of effective safeguarding practice within other care contexts (Appleton, 2009; Harbottle, 2007). It was necessary to review this burgeoning evidence base to identify factors that facilitate effective implementation of adult safeguarding more generally, in order to interpret the empirical findings reported in this thesis. A realist approach was adopted, due to its ability to consider contextual differences when examining the effectiveness of intervention strategies and incorporate a wide range of evidence (McDonald et al, 2016; Wong et al, 2010; Wong et al, 2013).

Systematic literature reviews are typically recognised as the hallmark of evidence based research synthesis and are essential to ensure the provision of '*best practice and reduce variations in healthcare delivery'* (Green, 2005, p.270; Gopalakrishnan & Ganeshkumar, 2013). Two of the mainstream approaches to systematic research review for evidence-based policy (EBP), are Meta-Analyses and Narrative Review.

Meta-analyses typically determine the net effect of different types of programmes and thus favour a baseline of studies using randomised controlled trials (Pawson, 2001). Contrastingly, narrative reviews for EBP summarise what is known on a given topic, search for desirable combinations between identified factors that make a programme successful, and make recommendations for the design of future programmes based on these success indicators (Pawson, 2001). Although each approach assumes a contrasting perspective on causality, ontology and generalisation, both are methods for evaluating research to determine whether programmes work (Pawson, 2001).

In contrast, realist synthesis offers a model that is *'compatible with the complexities of the modern health service and sympathetic to the usage of a multi-method, multi-disciplinary evidence base'* (Pawson, 2001; Pawson et al, 2004, p.3). Realist synthesis achieves this by focusing on the underlying reasons or resources that generate change as a by-product of such programmes. Realist synthesis therefore produces a theory of change that is context, subject and situation specific as opposed to maintaining a 'one shoe fits all' approach (Pawson et al, 2004; Pawson, 2001). Proponents of realist synthesis, assert that changes in the way in which health services are delivered are theories in themselves as *'they begin in the heads of policy makers, pass into the hands of practitioners and managers and, sometimes, into the hearts and minds of users and participants*' (Pawson, 2001, p.3). Realist assumptions assert that interventions are active programmes within which the reasoning and knowledge of stakeholders is central. Hence, it is expected that in order to identify the successes and failures of an intervention this knowledge must be captured (Pawson et al, 2005).

The realist review method is not a protocol-driven approach rather it is a set of principles used to illustrate the judgements of the reviewer based upon his / her interpretation of empirical research (Pawson, 2006). Some researchers have begun to articulate the suitability of realist synthesis to implementation research. More specifically, realist synthesis can be used to focus on the mechanism of action or change with regard to the implementation of an intervention, and identify what it is about an intervention that makes it work (or not) in a given context (Rycroft-Malone, 2012). Through the use of this flexible all-encompassing approach the researcher can address the complexity of real-life implementation (Rycroft-Malone, 2012). This method was deemed the most suitable for the present literature review for the reasons discussed below.

The predominant theme of adult safeguarding literature is the effective implementation of robust adult safeguarding systems across national services. As realist synthesis attempts to *'articulate underlying programme theories and then to interrogate the existing evidence to find out whether and where these theories are pertinent and productive'* (Pawson, 2006, p.74), it is a worthy companion of implementation research. In addition, the future development of this emergent area requires that empirical studies focus on barriers at which the implementation of evidence-based practice can fail and ways in which these might effectively be addressed (Proctor et al, 2009). This is also

particularly relevant for the present review, as much of the empirical literature on adult safeguarding focuses on barriers and factors associated with effective practice.

One of the challenges associated with improving Evidence Based Policy (EBP) in healthcare is the complex and multifarious nature of modern health service delivery (Cabinet Office, 1999). Indeed, it is suggested that to evaluate research pertaining to health service delivery, it is necessary to incorporate a broad and varied body of evidence such as, surveys and opinion polls; experimental and quasi-experimental trials; process and developmental evaluations; documentary and content analysis, and grey literature (Cabinet Office, 1999; Pawson, 2001; Pawson et al, 2004; Pawson, 2006). Due to the lack of empirical studies that focus specifically on mental health services it was necessary to include a broad range of evidence in this literature review. In addition, there is no contextual guidance available to mental health services about how to implement adult safeguarding practices across their services. Hence, the broader aim of the present review is to synthesise the range of evidence available to aid the identification of barriers and facilitators of effective adult safeguarding practice across NHS health services.

6.2 Method

6.2.1 Scope of Review

The purpose of this review was to identify factors that are associated with the effective implementation of adult safeguarding practice within healthcare organisations. The review specifically aimed to examine the range of implementation strategies used in NHS services, to identify factors that facilitate or hinder the establishment of effective practice. Realist reviews follow a number of sequential steps, as shown in Table 6.1. Collectively, these steps facilitate identification of the relationship between context, mechanism and outcome of a program or intervention, to articulate its underlying theory (Wong et al, 2010; Wong et al, 2013). The overarching aim of the synthesis is to compare *'how a programme is supposed to operate'* to the *'empirical evidence on its actuality in different situations'* (Wong et al, 2010; Wong et al, 2013). For the purpose of making such comparisons it is firstly necessary to identify the theoretical drivers that inform the programme or intervention and develop an *initial programme theory* about how it is intended to work in practice (Rycroft-Malone et al, 2012). The development of the initial programme theory will be discussed in the next section.

Table 6.1. Realist Review Steps and Activities

Phase	Activity
1. Scope of the review	Formulate research question, refine purpose of the review
2. Locate theoretical drivers	Initial search for theories that inform the program
3. Search for evidence	Decide search terms and data sources for main searches; conduct systematic database searches
4. Review and analyse data	Extract data and analyse for interactions between context, mechanism and outcome
5. Synthesise findings	Synthesise findings and compare with 'initial programme theory'
6. Develop narrative	Report findings with conclusions and recommendations

Adapted from Pawson et al, (2004) and Elliot et al, (2016)

6.2.2 Locating Theoretical Drivers

To identify the theoretical drivers intended to support the successful implementation of adult safeguarding within services, the researcher undertook an initial exploratory literature review. The range of literature consulted, included policy and guidance documents, competency frameworks, commentary papers, public inquiries, survey / statistical data and a range of government documents. For the purpose of extracting general theories of implementation, the researcher also consulted the body of theoretical literature relevant to using or *'integrating EBIs (evidence-based interventions) within a specific setting'*, known as 'implementation science' (Brownson, Colditz, & Proctor, 2012, p.229). The literature used to identify the theoretical drivers that inform the successful implementation of adult safeguarding within health services is presented in Table 6.2. The *initial programme theory* developed using this literature will be presented in the next section.

Table 6.2. Literature Consulted to Locate Theoretical Drivers

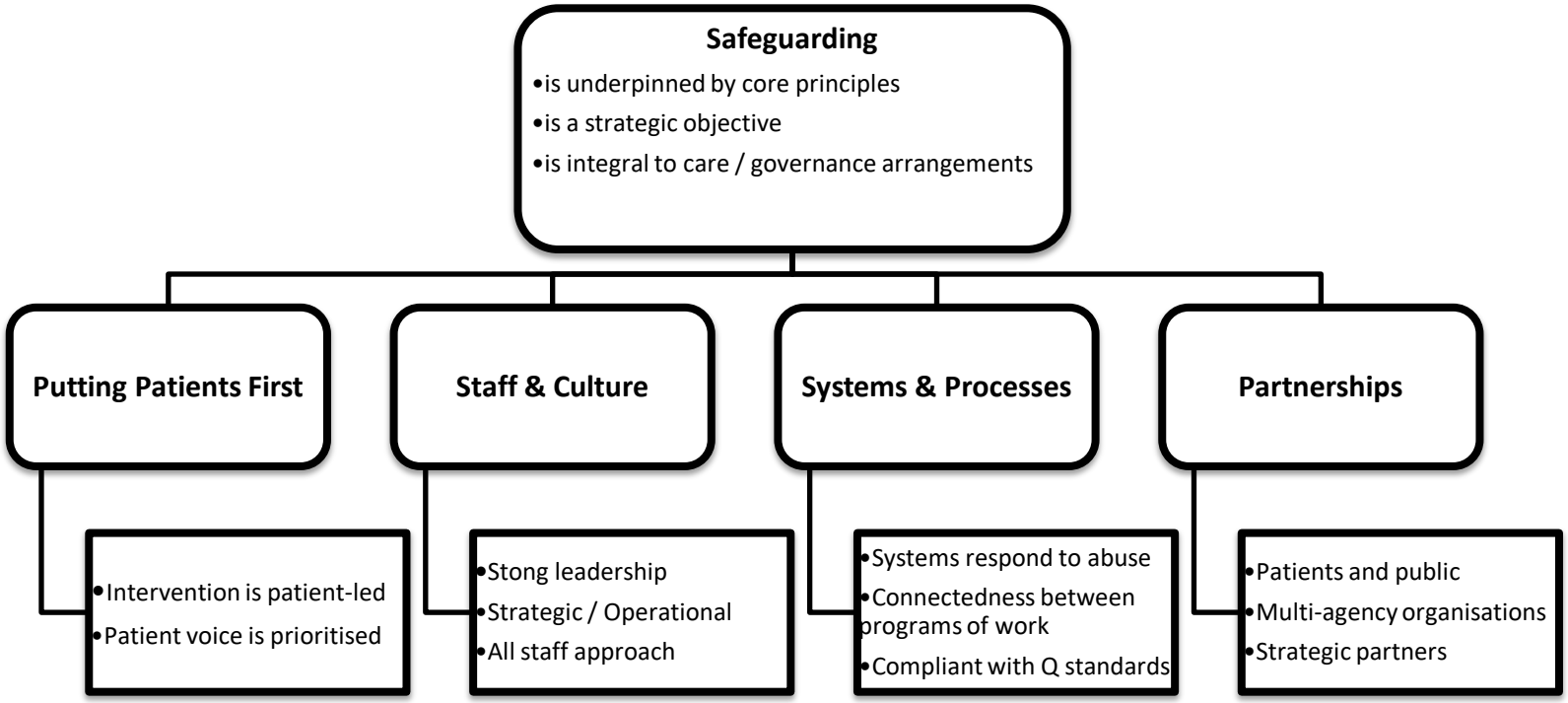
	Authors	Title
	Advice and Guidance	
1.	National Authorities (1998)	*United Kingdom: Human Rights Act*
2.	Department of Health (2000)	*No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*
3.	Welsh Assembly Government (2000)	*In Safe Hands: Implementing adult protection procedures in Wales*
4.	Association of Directors of Social Services (2005)	*Safeguarding Adults: A national framework of standards for good practice and outcomes in adult protection work*
5.	Natinal Authorities (2005)	*United Kingdom: Mental Capacity Act*
6.	Department of Health (2009)	*Safeguarding Adults: Report on the consultation of the review of 'No Secrets'*
7.	UK Parliament (2010)	*Equality Act*
8.	Galphin & Morrison, (2010)	*National Competence Framework for Safeguarding Adults*
9.	Department of Health (2010a)	*Clinical Governance and Adult Safeguarding: An integrated process*
10.	Department of Health (2010b)	*Practical Approaches to Safeguarding and Personalisation*
11.	Department of Health (2011a)	*Safeguarding Adults: The role of heatlh service managers and their boards*
12.	Department of Health (2011b)	*Safeguarding Adults: The role of health service practitioners*
13.	Department of Health (2014)	*Care and Support Statutory Guidance: Issued under The Care Act (2014)*
14.	Department of Health (2015)	*Safeguarding Vulnerable People in the NHS: Accountability and assurance framework*
15.	Graham, Norie, Stevens, Morriarty, Manthorpe, Hussein (2016)	*Models of Adult Safeguarding in England: A review of the literature*
16.	NHS England (2017)	*Safeguarding Adults: a guide for healthcare staff*
	Theoretical Literature	
17.	Van De Ven & Poole (1995)	*Explaining Development and Change in Organizations*
18.	Kitson, Harvey, McCormack (1998)	*Enabling the Implementation of Evidence-Based Practice: A conceptual framework*
19.	Nilsen (2015)	*Making Sense of Implementation, Theories, Models and Frameworks*
20.	Goes, Friedman, Seifert, & Buffa (2000)	*A Turbulent Field: Theory, research, and practice on organizational change in health care*
21.	Kezar (2001)	*Understanding and Facilitating Organizational Change in the 21st Century: Recent research and conceptualizations*
22.	Ferlie & Shortell (2001)	*Improving the Quality of Health Care in the United Kingdom and the United States: A framework for change*
23.	Rycroft-Malone (2010)	*Promoting Action on Research Implementation in Health Services (PARIHS)* In Models and Frameworks for Implementing Evidence-Based Practice : Linking Evidence to Action
24.	Grol, Wensing, Eccles & Davis (2013)	*Improving Patient Care: The implementation of change in health care*

6.2.3 Initial Programme Theory

Advice and Guidance

It is recommended that the development of adult safeguarding practice in health and social care settings is underpinned by six core principles: *empowerment, prevention, protection, proportionality, and partnership* (DH, 2011a; 2014). Collectively these principles stipulate that priority is given to supporting people to make informed decisions, ensuring that safeguarding activity is '*person-led and outcome-focused'* (DH, 2014, p.233). Prevention of harm should be the predominant focus and support and representation should be provided to those with the greatest need. Responses to incidents should be proportionate to the risk presented and the least intrusive to those at risk. In addition, services are required to be transparent and accountable for their actions, and establish strong working partnerships within their communities and local services, to devise appropriate solutions (DH, 2011a; 2014). To ensure these principles are integral to the delivery of healthcare, services are advised to adopt a structured approach to implementation. More specifically it is suggested that the development of adult safeguarding practices is modelled within the framework presented in *Figure 6.1*.

Figure 6.1. Proposed Framework for Development of Adult Safeguarding Practice in Healthcare Services



(Adapted from DH, 2011a; 2014)

An Integrated Approach

To ensure that adult safeguarding is considered at the level required for it to be given the utmost priority, it is imperative that it is established as a strategic objective (DH, 2011a). Services are specifically advised to align adult safeguarding work with key policy areas such as, delivering care in diverse care settings, equality, and patient experience (DH, 2011a). In addition, services must have clear definitions of abuse and neglect[26] with sufficient detail provided to address any ambiguities that may arise in practice. A number of guidance documents (DH, 2000; Welsh Assembly Government, 2000; ADSS, 2005; Galphin & Morrison, 2010; DH, 2011a; DH, 2011b) are available that provide in-depth information regarding: the types and patterns of abuse and neglect, who might be at risk, identifying perpetrators, and recognising signs and symptoms of abuse and neglect. A range of scenarios that may occur in practice are also considered within the literature. As such, the definitions and guidance developed by services should be consistent with current guidelines.

Putting Patients First

Adult safeguarding activity should prioritise the individual needs of service users in a *'personalised'* way (DH, 2014). In particular, safeguarding approaches should acknowledge that each person is *'an individual with strengths, preferences and aspirations'* and place them at *'the centre of the process of identifying their needs and*

[26] For definitions and classifications of abuse and neglect, please see appendix 6a

making choices about how and when they are supported to live their lives' (DH, 2010b, p.8). Indeed it is suggested that responses to safeguarding issues must enhance service-user choice and control, and strive for improvements to quality of life, wellbeing and safety (DH, 2014). Of particular importance when considering safeguarding interventions within services is use of, and compliance with the Equality Act (2010) and the Mental Capacity Act (2005). Evidence indicates that non-compliance with these acts has resulted in prosecutions against individuals and services, for failing to provide adequate care, restrictive care practices, and failure to make reasonable adjustments (DH, 2014). Consideration of carers and family members within the safeguarding process is equally important. Services are required to respond appropriately to circumstances where carers have experienced harm at the hands of the person they care for, are responsible for abuse or neglect of a person at risk, or bear witness to abuse or neglect (DH, 2014). This may involve a needs assessment for both the carer and the person at risk, or the appropriate escalation of concerns that are raised by carers (DH, 2014).

Staff & Culture

Advice and guidance places considerable emphasis upon the need for vigilance among professionals, staff, and members of the public, to ensure they are aware of the types and patterns of abuse and procedures for reporting – ultimately *'safeguarding is everybody's business'* (NHS England, 2017, p.5; DH, 2011b). Furthermore, it is the practitioner's responsibility to uphold the six core principles of adult safeguarding within

all related activity (NHS England, 2017). The prevention of abuse and neglect greatly hinges upon the willingness of all staff members to recognise and accept their responsibility for adult safeguarding (NHS England, 2017). Effective approaches to adult safeguarding require strong leadership that permeate to the uppermost level. Services are required to ensure that a robust leadership structure is in place with clear lines of responsibility at the following levels: strategic, operational / clinical, multi-agency representation, and front-line (NHS England, 2017). Nominated leaders should include a senior manager with responsibility for leading on organisational and inter-agency arrangements and Chief Executive Officers (CEOs) who have oversight responsibility and accountability for the strategic plan and contributions to the annual report (DH, 2014). In addition, responsibilities designated at each level should be specified within job descriptions and the skills required to fulfil these roles should be in line with existing competency frameworks (NHS England, 2017; Galphin & Morrison, 2010).

Systems and Processes

Services are required to implement and continually audit adult safeguarding policies and procedures, ensuring that they reflect current statutory guidance (The Care Act, 2014) and multi-agency arrangements (DH, 2014). Policies and procedures should facilitate *'swift and personalised safeguarding responses'* on behalf of staff members that optimise outcomes for service users (DH, 2014, p.241). Clinical governance systems should be used as a means to audit and benchmark clinical practice and compliance with quality and safety standards (DH, 2011a). Governance systems should also be used to ensure that responses to safeguarding concerns comply with multi-agency

expectations and recommendations for investigating safety incidents (DH, 2011a). Safeguarding intervention should be appropriate and determined by the circumstance – in many cases early sharing of information is key to ensuring that responses are effective. It is therefore expected that services will establish an information sharing protocol with partnership organisations (e.g. the Police, Social Care Services, relevant third sector organisations) (DH, 2014; ADSS, 2005). In addition, services are required to have clearly accessible procedures for recording complaints and incidents and be vigilant about involving other agencies where necessary (DH, 2014, p.245).

Integral to systems that buffer against abuse, harm and neglect is the establishment of a comprehensive training provision for staff and volunteers (DH, 2014). All staff members should receive training, albeit the level and content of which will depend upon individual roles and responsibilities. For example, all staff should receive basic adult safeguarding awareness or Level 1 training[27], which includes reporting responsibilities; however, individuals with responsibility for undertaking safeguarding enquiries require specialist training in this area (DH, 2014). Where possible staff members should be provided with multi-agency training opportunities '*to promote understanding of the roles of other partners'* (ADSS, 2005, p.19). In addition, service managers are required to provide regular supervision for staff members and encourage reflective practice to ensure staff members develop the necessary skills required to deal with a range of safeguarding issues. Of further significance is the development of rigorous recruitment

[27] Please see appendix 6b for the types and levels of training recommended within The Care Act (2014)

processes that utilise Disclosure and Barring Service (DBS) checks as standard, at the appropriate level according to the type of work required (DH, 2014).

Partnerships

The establishment of co-operative and cohesive partnerships should be at the centre of all safeguarding strategies (DH, 2014). Partnerships within NHS trusts should be developed at a number of levels - these include: strategic partnerships, local Safeguarding Adults Boards, and partnerships with service-users and carers (DH, 2011). The Safeguarding Adults Board (SAB), set up by the local authority (LA), is responsible for leading the strategic and operational arrangements within a locality (DH, 2014; ADSS, 2005). NHS trusts are responsible for the provision of senior and active membership on the local SAB. In addition, trusts are required to contribute to the setting and achievement of its outcomes, the development of transparent processes, and sharing learning with patients, public and multi-agency partners (DH, 2014).

Theoretical Literature

To develop plans for policy implementation, services should consult existing organisational change (OC) literature. Invaluable information regarding facilitators of change, stages and expected timescales of change, and strategies for outcome measurement (Kezar, 2001), can be used to bolster the advice and guidance offered to services to develop more robust plans. A multitude of OC models exist each with differing characteristics and assumptions (Kezar, 2001; Grol, Wensing, Eccles and

Davis, 2013). Goes et al (2000) in their universal conceptualisation of OC theories propose a pragmatic framing of OC models according to the: *level of change, type of change,* and *mode of change* (Goes, Friedman, Seifert, & Buffa, 2000). More recently, Nilsen (2015) presents five categories of theories, models and frameworks used to guide implementation science classified according to their core aims, namely: *process models, determinant frameworks, classic theories, implementation theories,* and *evaluation frameworks*.

Process models attempt to describe or guide the process of translation (e.g. Huberman, 1994; Landry, Amara & Lamari, 2001; Grol & Wensing, 2004; Graham et al, 2006); while determinant frameworks (e.g. PARIHS, Rycroft-Malone, 2010, Kitson et al, 1998; Ferlie & Shortell, 2001), classic theories (e.g. Theory of Diffusion, Rogers, 2003), and implementation theories (e.g. Normalisation Process Theory, May & Finch, 2009) attempt to explain, understand or predict what influences implementation outcomes (Nilsen, 2015). Finally, evaluation frameworks attempt to evaluate implementation to determine success (e.g. RE-AIM, Glasgow et al, 1999). In view of the emphasis placed upon factors that facilitate effective adult safeguarding practice within existing literature, it is reasonable to suggest that frameworks that focus on explaining or predicting outcomes (classic theories, determinant frameworks, and implementation theories) are of most relevance; however, frameworks that attempt to evaluate implementation (evaluation frameworks) would also be considerably important. Examination of existing literature revealed that some models have been highlighted as particularly suitable to healthcare innovation.

Relevant Implementation Models

Approaches relevant to the improvement of quality and outcomes in healthcare include the multilevel approach to change developed by Ferlie & Shortell (2001). Within their 'determinant framework' Ferlie & Shortell (2001) focus on the *'level of change'* and identify four levels at which change should be directed, namely: the individual, the group or team, the overall organisation, and the larger system or environment (Ferlie & Shortell, 2001, p.283; Nilsen, 2015). It is argued that all change interventions – top-down (Van Meter & Van Horn, 1975) or bottom-up (Linder & Peters, 1987) – must be aimed at all four levels to effect change successfully (Ferlie & Shortell, 2001). It is not suggested that all levels must be addressed simultaneously; however, the development of change interventions at each level must be considered within the context of the other three levels in order to maximise the potential for success (Ferlie & Shortell, 2001).

The Promoting Action on Research Implementation in Health Services (PARIHS) framework (Kitson et al, 1998; Rycroft-Malone, 2010) is also particularly applicable to the implementation of evidence-based practice in healthcare. This framework similarly posits that determinants of success are based upon viewing systems as an integrated whole (Rycroft-Malone, 2010). It suggests that *'successful implementation (SI) is a function of the nature and type of evidence (E), the qualities of the context (C) in which the evidence is being introduced, and the way the process is facilitated (F); SI = f(E,C,F)* (Kitson et al, 1998; Rycroft-Malone, 2010, p.111). Within this approach success is enacted through a combination of, quality *evidence* that prioritises the needs and views of patients, a *context* that incorporates *'sympathetic cultures, strong leadership, and*

appropriate monitoring and feedback systems', and implementation by highly skilled facilitators (Rycroft-Malone, 2010, p.113)

The PARIHS framework (Kitson et al, 1998; Rycroft-Malone, 2010) and the 'Levels of Change' theory (Ferlie & Shortell, 2001) are both significant to the implementation of adult safeguarding within NHS trusts. Given the emphasis placed upon adopting strategies that prioritise the needs of patients, to ensure that '*safeguarding is everybody's business',* and maintain safeguarding as a strategic imperative that reflects multi-agency and national objectives (DH, 2009, 2010a, 2010b, 2011a, 2011b 2014; NHS England, 2017, p.5); a multi-level approach or PARIHS framework would be appropriate. To achieve a multi-level approach, policy initiatives must be *'aligned with and supportive of the goals and objectives of health care organisations'* (Ferlie & Shortell, 2001. p.288).

Similarly, the structure of the organisation should facilitate efforts at the group / team level, who in turn must ensure that individual members have the variation of skills and competencies required to deliver quality interventions (Ferlie & Shortell, 2001). The PARIHS framework places considerable emphasis on the context, identifying it as *'a mediator of change and innovation in healthcare organisations'* (Dopson & Fitzgerald, 2005, p.79). This is particularly relevant considering the multi-disciplinary nature of adult safeguarding and the contextual differences likely to impact the success of implementation across settings. Numerous challenges may be encountered with

establishing either of these approaches; such challenges might include failure to anticipate barriers at differing levels and establish strategies for dealing with resistance (Ferlie & Shortell, 2001).

6.2.4 Search for Evidence

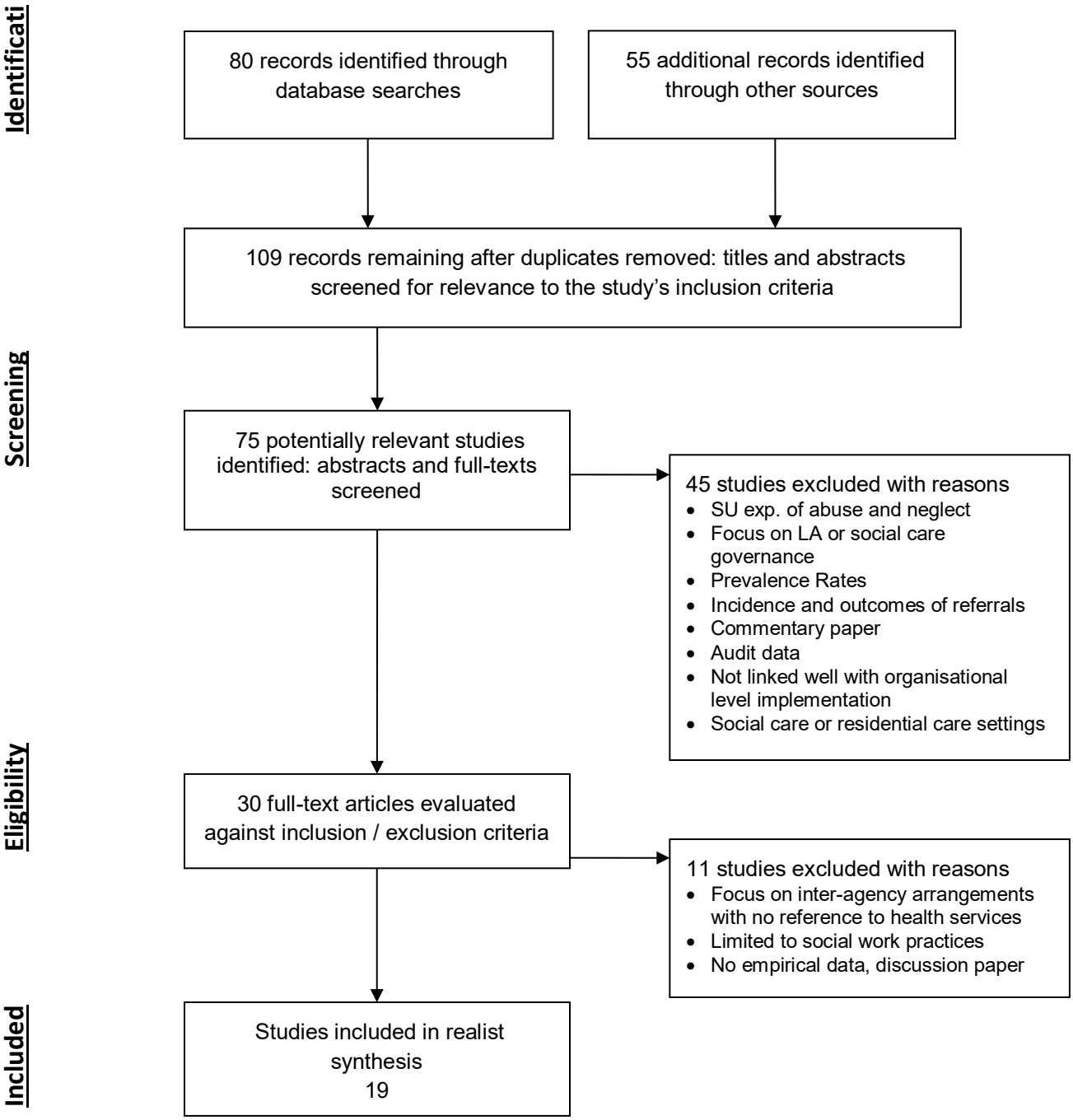
A systematic search of the following databases was conducted to identify empirical literature: CINAHL, MEDLINE, PubMed, PsycINFO, PsycARTICLES, BNI, Cochrane Library and OpenGrey. The Boolean terms and search strings used to identify literature can be seen in Table 6.3. Due to the paucity of literature identified through systematic searches, citation chaining was used to identify further potentially relevant articles. In addition, comprehensive searches of government and organisational websites were undertaken (Table 6.3). The aim of the search was to identify literature related to the implementation or development of adult safeguarding practice or policy with a particular focus on the development of evidence-based practice in healthcare. Studies published in the English language since the introduction of the *No Secrets Guidance* (2000) to the date of the final searches (2019) were included in the review. Safeguarding children was treated as a separate, but related topic hence studies that made comparisons between these initiatives were included. Initially a decision was made to exclude papers that focused on the implementation of Irish / Scottish Legislative Frameworks, due to substantial differences between the governance arrangements and policy initiatives for adult safeguarding in these countries. However, examination of this literature revealed findings relevant to the conceptualisation of successful implementation more broadly.

The strategy for study selection is presented in Figure 6.2 with reasons for exclusion provided.

Table 6.3. Systematic Search Terms, Databases and Websites

Boolean Terms and Search Strings	Databases	Websites
3. Adult AND safeguarding OR protection 3.1. AND Practice OR Policy OR Procedure 3.2. AND strategy/strategies (strateg*) OR approaches (approach*) techniques (technique*) OR methods 3.3. AND implement/implementing/implementation (implement*) OR evidence OR evidence-based practice OR ebp OR best practice effective/effectiveness (effective*)	➢ CINAHL ➢ MEDLINE ➢ Psycharticles ➢ PsychINFO ➢ PubMed ➢ BNI ➢ Cochrane Library ➢ OpenGrey	➢ DoH ➢ Mind ➢ Rethink ➢ NAO ➢ NRLS ➢ Community Care ➢ Social Care (SCIE)

Figure 6.2. PRISMA flowchart of search strategy



6.2.5 Data abstraction, synthesis and analysis

A formal appraisal process was not utilised in the present review, due to the considerable lack of methodological rigour in the studies identified. It was therefore determined that studies would not be selected based upon a rudimentary quality score that did not represent the research area. However, the researcher carefully examined each of the articles in relation to their relevance to the review aims and the inclusion and exclusion criteria (discussed above). The researcher read the articles and extracted key information, which was stored in an Excel spreadsheet. The extracted information included: research design and methods, participants and settings, inclusion of theory or frameworks, key findings, and conclusions and recommendations. Based upon the assumption that *'programme theories work in some settings and not others'* the aim of the synthesis was to conceptualise the success (or not) of adult safeguarding across health settings and compare national expectations of the programme with actual practice (Pawson et al, 2004, p.25). More specifically, the theoretical drivers discussed above (see 'Initial Programme Theory') have been summarised in Table 6.4 and were used as a point of comparison between empirical evidence and programme expectations. With this in mind data was extracted and categorised according to the themes / theoretical drivers presented in Table 6.4.

Table 6.4. Summary of Theoretical Drivers

Theoretical Drivers
A. Safeguarding is strategic, integrated and underpinned by core principles
B. Intervention is patient-led and prioritises the involvement of carers and family members
C. Staff recognise and accept responsibility, and leadership is multi-layered
D. Systems and processes are responsive, connected, compliant, and vigilant
E. Cohesive partnerships are established with patients and the public, multi-agency organisations and strategic partners
F. Approaches to change are targeted at multiple levels and relevant theoretical models are considered

6.3 Results

Despite an abundance of literature relevant to the development of adult safeguarding practice, there is a considerable lack of empirical focus on the application of safeguarding in practice within NHS health services. The majority of the available literature focuses on the establishment of multi-agency arrangements or is specific to the discipline of social care. Empirical literature related to adult safeguarding practice in healthcare settings has focused predominantly on the challenges associated with protecting people with learning disabilities (Faulkner & Sweeney, 2011). Furthermore, studies in this area are usually small-scale with limited generalisability, there is little evidence of what works in practice, interventions focus heavily on training and education, and there are considerable definitional issues with multiple interpretations of adult safeguarding terminology in different contexts (Faulkner & Sweeney, 2011).

Nineteen studies were selected for review and used to interrogate the expectations of the programme theory compared to actual practice. The identified studies included: four evaluations of interventions (2 training packages, 1 audit tool, and 1 implementation model); seven qualitative studies (six used qualitative interviews, 2 incorporated additional methods, and 1 used a focus group method); five literature reviews, one quantitative study, one survey, and one reflective piece. Empirical studies were limited and those that were identified lacked methodological rigour. Thirteen studies focused on practices in England, one study considers England and Wales, four explored practices associated with the Scottish framework, and one considered Wales only.

Table 6.5. Summary of studies included in Review

Authors and Year	Country	Innovation / Intervention	Research Design and Method
Aylett (2009)	England	Multi-agency training package	Evaluation / Report
Butler (2004)	England	Development and trial of an audit tool	Evaluation / Report
Cambridge & Parkes (2006)	England	Joint investigation multi-agency training module	Tasked assignments completed by health and social care staff, evaluation / report
Campbell (2014)	Scotland	Training intervention	Pre-and-post training test
Draper et al (2009)	England	Strategy to develop adult safeguarding practice in PCTs in Kent and Medway	Reflection / Discussion Paper
Faulkner & Sweeney (2011)	England	A review of literature on methods that prevent abuse	Literature review
Fennell (2016), Scotland	Scotland	Factors and barriers to reporting AP concerns among NHS professionals	Literature review, survey, semi-structured interviews
Harbottle (2007)	England	LA case managers knowledge and experience of chairing meetings, benchmarks and thresholds, current practice and required skills	Focus Groups
Jenkins et al (2007)	Wales	Multi-phase study of adopting a zero tolerance policy towards abuse in services for people with intellectual disabilities	Literature review, survey, focus group (FG results reported)

Kalaga and Kingston (2007)	Scotland	Primary, secondary, tertiary interventions that prevent and respond to abuse and neglect	Literature review
McCreadie et al (2008)	England	Implementation of multi-agency policy using the 'ambiguity-conflict model'	Qualitative Interviews
Nash et al (2010)	England	A triggers protocol for AS referrals adopted in two Trusts and the Police service in Cornwall	Thematic analysis of police records, qualitative data
Perkins et al (2007)	England	Exploration of perceptions of partnership working and regulatory framework	Survey
Ramsay (2009)	England	Implementation of adult safeguarding using a business case	Business case, report of activities used to promote AS
Stevens (2015)	England	The contribution of leadership to safeguarding adults in healthcare and establishment of a leadership framework	Literature Review
Stevens et al (2017)	England	Analysis of AVA data used to identify four structural models of adult safeguarding used by local authorities / local organisations	Quantitative analysis of referral data submitted to AVA (Safeguarding Adults Returns)
Taylor & Dodd (2003)	England	To explore staff knowledge and attitudes of abuse and reporting procedure to better understand factors that hinder reporting	Qualitative interviews
Wallcraft (2012)	England and Wales	To summarise findings of a review of service-user and carer involvement in adult safeguarding	Literature review, telephone interviews, consultation
Burns (2018)	Scotland	Evaluation of adult support and protection process	Qualitative interviews service users, carers and staff

6.3.1 Safeguarding is strategic, integrated and underpinned by core principles

Historically *'adult protection amongst everything else in the NHS'* has not been *'a high priority'* (McCreadie, 2008, p.260). It was commonly regarded as an *'add-on'* to regular duties with inconsistent engagement with multi-agency initiatives (McCreadie, 2008, p.260; Draper, Roots & Carter, 2009). While practice was advancing rapidly among partnership agencies, some NHS trusts were failing to provide staff with policies to help *'identify and manage possible abuse'* and were reliant upon child protection officers to provide this advice (Ramsay, 2009, p.25). Indeed, Ramsay (2009) suggests that awareness of the concept of vulnerable adults was poor among NHS staff, albeit many were raising concerns about unethical practices without explicitly linking these with adult safeguarding (Ramsay, 2009). Systemic malpractice in long-term inpatient settings resulted in unacknowledged abuse incidents, tolerance of patient-to-patient aggression, and dilatory reporting practices (Fennell, 2016). Individuals brave enough to voice their concerns were acknowledged for their courage, which was more likely to occur in environments that nurtured open and honest discussion (Fennell, 2016).

Over the past decade improvements to practice are evident with trusts adopting various strategies to integrate adult safeguarding within mainstream care. Approaches vary and include the provision of adult safeguarding specialists in the form of two or three person teams or larger combined child protection and adult safeguarding teams (Draper et al, 2009). In addition the majority of trusts have designated adult safeguarding lead nurse roles (Draper et al, 2009; Ramsay, 2009). In many trusts attempts have been made to

mirror arrangements for child protection to ensure adult safeguarding is considered on an equal footing (Headrick & Khaleel, 2008; Harding, 2004). Additional strategies with a preventative focus may be employed to improve care quality. For example, 'whistle blowing' is crucial to the exposure of abuse and neglect and should therefore be central to strategies for integrated provision (Kalaga & Kingston, 2007).

6.3.2 Intervention is patient-led and prioritises the involvement of carers and family members

The involvement of service users, carers and family members in the planning and delivery of services is increasingly considered essential to the provision of quality healthcare. Service-user and carer involvement is viewed by some as a reflection of contemporary societal ideals that must not be treated as a transient issue (Kemp, 2010). Approaches to involvement may include patient and public involvement and engagement (PPIE), shared decision-making, and various forms of co-production (Mind, 2013; Coulter, 2009; Brett et al, 2014). Despite the widespread use of these approaches across healthcare disciplines, the involvement of service-users in adult safeguarding procedures remains a challenge. Practitioners highlight issues with achieving a balance between an individual's rights and the risks associated with making 'poor' choices (Fennell, 2016). As a result, the actions of staff may contravene a service user's wishes *'service users often just want the abuse to stop, they don't necessarily want a conviction or something like that. We need to remember that'* (Wallcraft, 2012, p.146).

Nevertheless, a number of proactive strategies are used by services to promote service user involvement in adult safeguarding. These include: procedures for service user involvement in investigations; advocacy and support services; evaluation of service user satisfaction with services; and exploration of individual experiences of safeguarding procedures (Cambridge & Parkes, 2006; Braye & Preston-Shoot, 2012; Wallcraft, 2012). Positive feedback has been received for a number of survey or audit type approaches used to explore service users experiences of safeguarding procedures (Wallcraft, 2012). These range from: case file audit teams that include service users; supported completion of assessment forms for service users; and training of people with learning disabilities to contribute to staff training, or to offer peer-to-peer support to those currently going through the process (Wallcraft, 2012). Community conferences, information sharing leaflets, plain English summaries of Safeguarding Adults Board (SAB) decisions, and easy-to-read versions of audit tools, are also being used to engage service users and carers in the process. Research highlights that service-user involvement is having a considerable impact on adult safeguarding practice, indeed questions raised by service-users have resulted in improved accountability of staff and SABs (Wallcraft, 2012).

In one trust, care co-ordinators visit service-users who are unable to attend case-conferences in their homes to provide updates on proceedings. Service-users appreciate personalised feedback delivered in this way and value the kindness of staff members who display the '*right attitudes'* (Wallcraft, 2012, p.147). An evaluation of the

Scottish Adult Protection and Support Process (ASP) using service users trained as peer researchers revealed that service users felt respected, generally clear about the process and felt safer; however, there was some variability in the feedback received about individual stages of the process (Burns, 2008). In particular, some participants reported being less clear about the purpose of, and process during, inquiry and investigation stages. Strategies for improving such issues might include the use of advocacy services to ensure the 'at risk' adult is supported throughout the investigation (NHS Highland, 2005; Kalaga & Kingston, 2007, p.13). The use of interpreters may also be required to ensure the voice of the service user is heard. Strategies such as these are likely to have an empowering affect on service-users who are at the centre of abuse investigations (Kalaga & Kingston, 2007).

Training designed to keep service-users safe that is customised to the particular needs of individual groups is also increasingly used to promote prevention (Faulkner & Sweeney, 2011; Singer, 1996; Aylett, 2009). For example, Collins and Walford (2008) noted a *'sense of powerlessness and fear of retribution'* experienced by people with mental health problems (Faulkner & Sweeney, 2011, p.17). In response, training for this client group was designed to enhance confidence and develop assertiveness skills (Faulkner & Sweeney, 2011). Empowering service-users to exercise their right to choice and control in their lives may further minimise the risk of exposure to abuse or neglect (Aylett, 2009). Specific recommendations for enhancing service-user involvement in the safeguarding process include: exploring perceptions of safety specific to each

individual, involving people in safeguarding plans, training practitioners to record the views of service-users as standard practice, and to explore and identify relevant strategies for engaging service users within community or alternative settings as necessary (Wallcraft, 2012).

6.3.3 Staff recognise and accept responsibility and leadership is multi-layered

The most commonly used strategy adopted by NHS services to promote staff acceptance of responsibility for adult safeguarding is training and education. Indeed, the majority of literature that focuses on the development of practice or implementation includes discussion of strategies for training and education (Kalaga & Kingston, 2007; Marsland et al, 2007). In the immediate years following the publication of the *No Secrets* guidance (DH, 2000) attendance at training by health staff was inconsistent (Draper et al, 2004). Many nurses prioritised the medical model and indeed disputed the suggestion that adult protection was their responsibility (Draper et al, 2009). Nursing staff also raised concerns about the increasingly burdensome reporting procedures for adult protection and insufficient time to complete related tasks (Draper et al, 2009). Staff training has become fundamental to the delivery of adult safeguarding across NHS services. Nevertheless, a lack of outcome measures to determine the success or failure of staff training leads to difficulties assessing ownership of adult safeguarding among staff members (Bernstein and Ziarnik, 1984; Cullen, 1988, 2000; Campbell, 2007).

Despite a paucity of research in this area, staff ownership of adult safeguarding may be gleaned through examination of responses to abuse incidents. Responses elicited via case studies for training purposes or posed as direct questions in research studies, highlight that health staff with greater exposure to abuse (e.g. learning disability services) are more aware of their responsibilities in comparison with those who are less experienced (e.g. older adult services) (McCreadie et al, 2008; Fennell, 2016). Members of staff in healthcare settings are also noted for their disacknowledgement of service-user abuse and tendency to prioritise abuse that is recurrent, intentional and '*severe enough'* (Taylor & Dodd, 2003, p. 28; McCreadie et al, 2008). Ambiguities also arise where proof of harm is deemed insufficient, incidents involve staff members, or a service-user has previously made false allegations (Fennell, 2016; Harbottle, 2007; Jenkins et al, 2007; Taylor & Dodd, 2003).

Furthermore staff members reveal a tendency to prioritise the needs of the service; *'Oh there's no money for that. I'm not going to challenge that. It's just tough, and you know, they don't get the service'* (Jenkins et al, 2007, p.3045). In such situations, staff members have been known to delay reporting or resolve issues in-house rather than raise concerns via multi-agency channels (Fennell, 2016; Harbottle, 2007). A further concern in relation to recognition of the need to report concerns is the tendency of staff to develop their own interpretations about levels of risk. In particular, individual interpretations of risk to abuse vary among staff members, who commonly recognise

the risks associated with learning disabilities or mental health problems, but perceive individuals with physical or sensory disabilities, as less vulnerable (Taylor & Dodd, 2003). Nevertheless, in most cases staff members recognise the importance of adult safeguarding and value the opportunity to share their concerns within multi-disciplinary or multi-agency contexts (Fennell, 2016).

Organisational culture is identified as particularly important to the prevention of abuse and neglect (Stevens, 2015). It is suggested that abuse thrives in cultures that are process-orientated as opposed to service-user centred and in some cases may explain abuse that is perpetrated by staff (Marsland et al, 2007). Positive cultures on the other hand challenge dominant views, foster openness and transparency, imbue philosophies of good practice and support those who escalate concerns (Calcraft, 2007; Grimshaw, 2012). Some staff members report reluctance to expose abuse perpetrated by colleagues and would assume that *'they were having a bad day'* before they would *'believe they were abusing'* (Taylor & Dodd, 2003, p.29). Indeed, some assert that they would broach the subject with a colleague first prior to reporting it officially (Taylor & Dodd, 2003). Staff members also express reluctance to report colleagues due to the potential discomfort of having to work with them afterwards or the possibility of no action being taken where perpetrators are friendly with senior colleagues (Taylor & Dodd, 2003).

The successful implementation of adult safeguarding is reliant upon committed leadership at all levels (Agnew et al, 2012). During the early years of implementation, the leadership of adult safeguarding across health services was inconsistent (Cambridge & Parkes, 2006). In some trusts, pursuit of adult safeguarding intervention was actively discouraged by managers (Cambridge & Parkes, 2006), managers failed to circulate policies and procedures among members of front-line staff, and in some localities communication between senior managers and *'lower grade'* managers was identified as ineffective (Draper et al, 2009). In addition, support offered to health staff who were involved in adult safeguarding investigations or procedures usually came from social services staff (Draper et al, 2009) In response to these identified issues trusts actively sought to introduce specialist lead roles or include adult safeguarding responsibilities in job descriptions for managerial posts (Draper et al, 2009).

Research on the current leadership of adult safeguarding in NHS trusts is scant. Stevens (2015) in a review of leadership within the context of safeguarding vulnerable adults, analysed leadership in relation to the delivery of patient care more generally and evaluated its potential contribution to adult safeguarding. Stevens (2015) highlights the need for lead posts for adult safeguarding (Torjesen, 2008; DoHC, 2008), and advocates the need for specialist leadership training courses, in line with comparable high-risk industries that acknowledge the indisputable link between effective leadership and safety (Agnew et al, 2012). In addition, characteristics of managers that are

essential to abuse prevention are identified, including: role modelling, willingness to challenge, and maintaining the accountability of staff (Calcraft, 2007; Agnew et al, 2012; Grimshaw, 2012). Furthermore, emphasis is placed upon the relationship between a reduction in adverse events and the approachability and openness of nurse leaders (Humphries, 2011).

Stevens (2015) proposes a leadership framework for adult safeguarding that suggests that effective transformational change should focus on three tiers: societal, organisational, and personal. More specifically, it is asserted that any change effort must first consider the wider societal context in which adults at risk exist, and evaluate the impact of such issues on operational practice (Stevens, 2015). Strategic leaders at the senior management level who are responsible for instigating organisational change must focus on establishing a 'just' and open culture that is proactive, accountable, collaborative and personalised (Stevens, 2015, p.268). Personal leadership emphasises that any member of staff has the power to *'show the way'* and can adopt a range of strategies within their individual practice that ensure safeguarding is a core part of delivery (Stevens, 2015; Sturmberg and Martin, 2012, p.18). Practice suggestions for practitioners include: being explicit in their support for adult safeguarding; avoiding complacency; communicating openly with colleagues; maintaining a balanced workload; being accountable; engaging with training and supervision; and challenging dominant views that contravene the prevention of abuse (Stevens, 2015).

6.3.4 Systems and processes are responsive, connected, compliant and vigilant

The searches undertaken for the present review did not identify research, which specifically examines the use and development of adult safeguarding policy and procedures within NHS health services. Similarly, research on the governance structures adopted by health services for adult safeguarding is also lacking, albeit some strategies are referred to within generic discussion of governance arrangements. It is suggested that the integration of adult safeguarding with clinical governance and patient safety is essential to systems that prevent abuse (DH, 2011a). In addition, services should establish standards of practice and strategies to measure day-to-day activity to ensure issues are identified early and appropriate intervention is implemented (Stevens, 2015). A clinical governance framework proposed by Arya & Callaly (2005) for the provision of mental healthcare, identifies the following essential components of an effective governance structure: clear concepts of accountability; clinical practice improvement; risk management; monitoring or evaluation of standards; and quality improvements (Arya & Callaly, 2005; Stevens, 2015).

A number of strategies are adopted by NHS health services to monitor adult safeguarding practice. Some trusts describe the development of audit tools for use on wards to assess the quality of care provided according to clinical governance standards (Butler, 2004). Such tools are highlighted for their contribution to the development of reflective practice and the continuous improvement of services (Butler, 2004). One primary care trust (PCT) describes development of a *triggers protocol* for use within the

ambulance service to identify high-risk calls, that are subsequently escalated to a clinical triaging team to identify the most appropriate intervention for individuals with complex social and medical needs (Nash et al, 2010). An electronic system was also developed to monitor admissions to Minor Injury Units (MIU) with alerts attached to individual records that send an email to the safeguarding team when activated. Feedback on these strategies highlights improved communication and information sharing between partnership agencies, as well as heightened awareness of the need to escalate concerns (Nash et al, 2010). Further recommendations include the incorporation of risk assessment plans in care planning initiatives to prevent abuse, neglect and exploitation (Choi & Mayer, 2000; McCreadie, 2001; CSCI, 2008).

The importance of staff training within NHS services is evidenced by a range of training provided by services and a predominant focus on training within existing literature. Campbell (2014) highlights three levels of training offered to NHS staff to improve knowledge and skills associated with ASP. *Level 1*, is described as *'basic awareness, knowledge, and understanding'* (Campbell, 2014, p. 18); *Level 2,* provides operational knowledge and understanding to enable the appropriate responses of staff who work directly with adults at risk; and *Level 3,* is similar to level 2, albeit is aimed at health service managers, police and other specialists (Campbell, 2014). A core training structure developed in Kent and Medway for the delivery of multi-agency training via a consultant identified six levels (Aylett, 2009). *Level 1*, similarly provides basic awareness and understanding of abuse; *Level 2*, focuses on the responsibilities of

practitioners to raise an alert and evaluate risk; *Level 3*, equips participants with the knowledge and skills required to undertake an investigation; *Level 4*, focuses on understanding of the role played by partnership agencies; *Level 5*, develops the competencies required for strategic decision-making, evaluating evidence, assessing risk, and implementing policy; and *Level 6* considers post abuse care (Aylett, 2009).

Adopting structured approaches to training such as those described facilitates the development of learning in a staged progression and the customisation of training packages according to the needs and requirements of particular job roles (Aylett, 2009). While the mode of delivery varies across localities, awareness training (level 1) is usually mandatory within NHS organisations and delivered in-house (Aylett, 2009; Campbell, 2014). Additional training strategies adopted in NHS services include the use of a *'market-stall'* to encourage staff to engage with training materials and raise questions in an informal manner (Ramsay, 2009, p.27) and refresher days offered on a bi-annual basis (Aylett, 2009). For localities that offer a multi-agency provision, the collaborative delivery between multiple professionals with a range of expertise is very well received (Aylett, 2009).

Formal evaluation of training is particularly difficult and predominantly relies upon qualitative feedback or attendance levels to determine compliance (Aylett, 2009; Campbell, 2014). Nevertheless, Campbell (2014) measured participants knowledge of

adult safeguarding pre-and-post training and found that participants' knowledge increased by between 2.5% to 27.5% overall. Campbell (2014) notes, however the difficulty in simulating the stresses experienced in real life situations within training approaches, thereby highlighting disparity between formal evaluation methods and the nature of day-to-day practice. Difficulties with defining outcome measures for staff training has resulted in a lack of available evidence to demonstrate the success or failure of training in relation to quality outcomes for adult safeguarding (Cullen, 2000; Campbell, 2007; Campbell, 2014). Feedback from participants suggests that training provides the knowledge required to raise an alert or make a referral, albeit it may be necessary to provide updates for those who have limited opportunity to test their learning in practice (Fennell, 2016). Participants also report feeling overwhelmed by the amount of policy and legislation they are required to keep up-to-date with (Parley, 2011); thus the need for services to ensure ease of access to up-to-date information is greatly emphasised (Campbell, 2014).

Following recommendations to strengthen procedures for the recruitment of staff to work with adults at risk, legislation for disclosure and barring procedures was introduced to promote the development of *'more rigorous, efficient and effective vetting'* arrangements for recruitment (Kalaga & Kingston, 2007, p.25). Despite this, Mustafa (2008) revealed that NHS organisations were employing individuals to work with adults at risk, prior to receiving disclosure checks on the basis that they would be supervised by senior team members (Mustafa, 2008). It is therefore essential that recruitment

strategies adopted by NHS services, consider individual decision-making processes, and provide clear and unambiguous guidelines to decision makers that maintain accountability (Mustafa, 2008). Of further significance is the role of supervision in reinforcing awareness, communicating policies, encouraging reflective practice, and detecting signs of inappropriate behaviour (Faulkner & Sweeney, 2011).

6.3.5 Cohesive partnerships

Research pertaining to the development of cohesive partnerships within the context of adult safeguarding focuses predominantly on multi-agency working. Indeed the *'proactive nature of partnership, a sense of shared responsibility, and enhanced operational capacity'* contribute to more strategically effective endeavours between the agencies involved (Perkins et al, 2007, p.14). Nevertheless the concept of multi-agency working is identified as particularly problematic due to substantial differences between the organisational cultures, hierarchical structures, and philosophies of practice among the different agencies (McCreadie et al, 2008; Action on Elder Abuse, 2006; Perkins et al, 2007). In particular, the tendency of individual organisations to prioritise their own processes impedes the progress made through multi-agency initiatives (McCreadie et al, 2008).

NHS trusts are commonly noted for a lack of engagement with multi-agency imperatives and a reluctance to accept responsibility (McCreadie et al, 2008). Historical issues

include: a lack of appropriate representation at committee meetings; a lack of familiarity with policies and procedures; and assertion that safeguarding is *'not our problem, that's social services'* (McCreadie et al, 2008, p.253). Despite such observations health staff report issues with, acknowledgement of their responsibility by other agencies, disagreements with social care staff regarding the right course of action, being excluded from the decision-making process, and poor communication (McCreadie et al, 2008). In addition, health services staff emphasise the importance of being taken seriously when referrals are made and highlight the need for assurances that they will be responded to appropriately (Fennell, 2016).

The achievement of mutual goals between health and social services has long been hindered by cultural, professional and organisational differences (Cambridge & Parkes, 2006). Indeed, fulfilment of the No Secrets (DH, 2000) recommendations for multi-agency working was stymied by a lack of strategies to enable harmonious engagement between health and social services managers and practitioners (Cambridge & Parkes, 2006). Attempts to bridge this gap include the development of a joint investigation training model that initiates co-ordinated efforts between health and social services practitioners to work collaboratively on cases (Cambridge & Parkes, 2006). Feedback on this model highlights a number of challenges associated with joint investigations, including: maintaining cross-agency updates throughout an investigation to ensure all parties are kept informed; the long-term monitoring of cases to ensure closure does not result in neglect; confidentiality, consent and information management across

professional groups; and obligations to share information in a multi-agency context that jeopardises a criminal investigation (Cambridge & Parkes, 2006).

Issues are also identified with engaging GPs, hospital consultants, psychiatrists and psychologists within the context of joint investigations; however the contribution of competing organisational priorities and workload pressures to this issue is highlighted. Further challenges are encountered with maintaining person-centred approaches to adult safeguarding in the context of multi-agency investigations whereby '*organisational pressures, priorities and constraints'* compete with the interests and involvement of the service user (Cambridge & Parkes, 2006, p.831). Case conferences are reported to have a positive influence on inter-professional and cross agency working and are deemed a facilitator of success (Cambridge & Parkes, 2004, 2006). Nevertheless, it is acknowledged that practitioner flexibility in terms of organisational boundaries and mutual respect of other professions is required to build a positive multi-agency culture (Cambridge & Parkes, 2006; Harbottle, 2007).

6.3.6 Targeted approaches to change and theoretical models

Stevens (2015) asserts that managing change is a complex process and *'changing organisational culture may be a long-term goal of healthcare organisations'* (Stevens, 2015, p.264). To implement change within organisations, buy-in from staff and recognition of the strategies required to embed policy is required (Daley, 2008). Indeed,

a lack of understanding and recognition of the need for change among staff members is identified as a common cause of resistance and failure (Curtis & White, 2002). Despite a clear need to consider facilitators of change when implementing adult safeguarding policy, few studies draw on theoretical models of change to develop approaches to implementation.

McCreadie et al (2008) in their study of adult protection utilise the *'ambiguity-conflict'* model developed by Matland (1995) to analyse work undertaken by health and social care agencies to implement and interpret adult protection policy. According to Matland's (1995) model, adult protection policy may be classified as high-ambiguity (due to its non-prescriptive nature and the freedom to align multi-agency policies with local requirements) / low-conflict (owing to the wide acceptance of the value of adult protection) (McCreadie et al, 2008). Matland (1995) indicates that high-ambiguity / low-conflict policy incurs variable standards of implementation, predominantly influenced by bottom-up, locally based factors (McCreadie et al, 2008). Such factors include: clarity surrounding the roles and responsibilities of partnership agencies; the quality of interagency working relationships and communication; eligibility of populations; commitment of resources; and accountability (McCreadie et al, 2008). Existing research further indicates that the implementation of policy at organisational level depends upon the significance of environmental and cultural influences on day-to-day practices (Jenness & Grattet, 2005).

McCreadie et al (2008) demonstrate that the ability of agencies to accommodate the *No Secrets* (DH, 2000) guidance varies according to the level of compatibility between newly implemented policies and the existing organisational culture. Particular discrepancies are identified in health organisations due to conflicting viewpoints regarding *'punitive responses to abuse and neglect'* (McCreadie et al, 2008, p. 262). Indeed, one healthcare practitioner declared that despite a number of major incidents in their service, disciplinary action was not taken against the staff members involved. This was attributed to a culture that promotes learning in place of punishment, despite evidence of wrongdoing or neglect on behalf of staff members (McCreadie et al, 2008).

Ramsay (2009) created a business case to secure support for the introduction of a clinical lead for safeguarding adults. Adapted from Rieley (2006) a *Theory of Change Implementation* was adopted as the underlying philosophy to propose a case for change to the hospital management team (HMT). The philosophy used comprised of five steps, namely: understanding the need for change, believing in the need for change, becoming involved in the change, witnessing the benefits of change, and talking to others about the benefits of change (Ramsay, 2009). In accordance with the model, the first step was to highlight the risks associated with not having an adult safeguarding strategy. The evidence presented included: staff concerns about restraint procedures; the absence of strategies for dealing with wandering / confused patients; service-user injuries associated with falls; complaints about a lack of appropriate care for people with learning disabilities; confusion about how to use the mental capacity act; statistics

revealing that adult abuse was on par with children; rates of women experiencing domestic violence; and evidence that service-users were reluctant and ashamed to report abuse (Ramsay, 2009).

The mechanism of change chosen by the HMT was the introduction of a temporary clinical lead for adult safeguarding. Amendments were also made to the adult safeguarding policy to include a section that addressed how to manage disagreements between healthcare professionals, as this had been a reported barrier to the effectiveness of child protection arrangements (Ramsay, 2009). The next stages involved launching a new policy, updating training modules; and development of strategies for maintaining staff training records, evaluation and audit, and external collaborations (Ramsay, 2009). Adherence to the change model in this case was not prescriptive, rather it was used as an underlying foundation to develop a strategy for implementation and promote change. The changes observed after six months of appointment to the post were promising and evidenced by an increase in referrals (Ramsay, 2009).

6.4 Discussion

The aim of this review was to identify factors associated with the successful implementation of adult safeguarding in NHS health services. In accordance with a realist review method, this review aimed to identify an initial theory of implementation

and compare this with practice based evidence to determine the success or failure of adult safeguarding implementation in healthcare. Systematic searches revealed that a majority of papers that consider the implementation of adult safeguarding, focus on the development of effective multi-agency practices. Given that the development of robust multi-agency arrangements is the predominant focus of the advice and guidance available, this is potentially unsurprising. Nevertheless, due to the continuous emphasis placed upon the disengagement of NHS partners with the adult safeguarding agenda (DH, 2000; DH, 2009); this oversight was unanticipated and indicates a potential indifference to the improvements required in this area.

Analysis of advice and guidance, and additional literature to develop the initial programme theory, revealed a robustly designed framework available to services for the purpose of establishing adult safeguarding arrangements within their organisations. The identified framework broadly recommends a structured and co-ordinated approach to implementation that is integrated, patient-led, strategically embedded, responsive, vigilant, collaborative, and multi-layered (DH, 2009, 2010a, 2010b, 2011a, 2011b, 2014). Comparisons were made between this initial programme theory and practice based evidence extracted from nineteen studies. The findings indicate that historically safeguarding was not a high priority in NHS services, but integrated provision is continually improving and the majority of trusts now have established adult safeguarding teams with designated lead posts (Draper et al, 2009; Ramsay, 2009). Nevertheless, contention exists regarding the benefits of using internal processes e.g. whistle blowing

(Kalaga and Kingston, 2007) and the risks associated with relying on such processes to solve issues in-house (Fennell, 2016).

Involving service users in adult safeguarding procedures is complex and practitioners experience conflict between balancing service-users rights and adherence to safeguarding protocol (Fennell, 2016). Despite this, a range of strategies are being used by NHS trusts to involve services users; the results of which are having an observable impact on the transparency of adult safeguarding practice (Wallcraft, 2012). For example, the review findings highlight the improved accountability of staff and Safeguarding Adults Boards (SAB) as a result of service-user input. Research in this area is potentially benefitting from the increasingly inclusive nature of healthcare provision and the wealth of involvement approaches developing across healthcare disciplines (Mind, 2013; Coulter, 2009; Brett et al, 2014). Indeed, innovative strategies reported in the literature include the use of advocacy services, interpreters, and service-user peer-to-peer support (Cambridge & Parkes, 2006; Braye and Preston-Shoot, 2012; Wallcraft, 2012); all of which are strategies that have emerged from within general healthcare practices, as opposed to being developed specifically within the remit of adult safeguarding.

Acceptance of responsibility among staff members was also not widespread during the initial years of implementation of adult safeguarding, which was highlighted

predominantly through engagement with training interventions (Draper et al, 2009). Barriers highlighted as specific to health contexts include a failure to recognise abuse between service-users, individual interpretations of thresholds of harm and levels of risk, and service-centred practices (Taylor & Dodd, 2003; McCreadie et al, 2008, Fennell, 2016). Despite evidence to suggest that such responses impede practice and serve to conceal abuse, few strategies were utilised to combat the effects of inappropriate responses. Of further concern was the tendency of staff members to prioritise their working relationships with colleagues above the safety of service-users (Taylor & Dodd, 2003). Although, the evidence presented reveals some concerning day-to-day practices, there is a considerable lack of outcome measures for staff training. Consequently, it is not possible to determine whether that which is provided adequately facilitates swift and personalised responses to abuse in NHS health services.

The findings reveal that the leadership of adult safeguarding has also been inconsistent, with poor communication, overreliance on social services, and failure to provide information highlighted in some trusts (Draper et al, 2009). Nevertheless, the findings also indicate that the personal characteristics of progressive managers may contribute to the prevention of abuse (Agnew, 2012; Grimshaw, 2012). In addition, cultures that inspire openness and transparency are suggested to empower staff members to champion adult safeguarding. Despite the identified facilitators of effective practice discussed, the leadership of adult safeguarding in NHS health services is almost entirely absent from existing research. It was therefore not possible to determine

whether practice in this area is effective or identify contextual factors that potentially foster effective leadership practices. It is highlighted, however that health representation on SABs in some localities is diverse, participatory and invaluable (Braye et al, 2012), indicating that there is a degree of variability in standards of leadership across services.

A number of innovative and customised approaches for the monitoring and governance of adult safeguarding are being developed; in some cases these have been influenced by local scandals e.g. prominent child abuse cases (Nash et al, 2010). The perceived importance of staff training is also evident in the range of training approaches and structures being developed and deployed across NHS trusts (Aylett, 2009; Campbell, 2014). In addition, the findings indicate that staff training is the most advanced area of adult safeguarding practice, with the majority of implementation efforts in NHS trusts focusing on this component. A number of barriers hinder the establishment of cohesive partnerships with multi-agency organisations, many of which are associated with historical practices and resistance within NHS services (McCreadie et al, 2008; Perkins et al, 2007; Cambridge & Parkes, 2006). Nonetheless, NHS partners also experience conflict from other multi-agency partners that negatively impacts productive collaborations (McCreadie et al, 2008). In addition, the longstanding misalignment between the goals of health and social care services is a particular barrier for multi-agency working.

Despite the significance of organisational change theory to policy implementation, few theoretical models were identified within the literature to aid the development of implementation approaches for adult safeguarding. Of those that were identified, one was used retrospectively to analyse the perceived ambiguity of newly implemented policies (McCreadie et al, 2008), and the other was used as an underlying philosophy with which to frame a business case (Ramsay, 2009). Although application of the models identified achieved positive outcomes, in both cases the models were directed at individual levels, as opposed to the multi-level approach recommended within the literature (Ferlie & Shortell, 2001; Nilsen, 2015). This highlights a potential failing of strategies within this area and a tendency of NHS health services to adopt poorly structured approaches to implement adult safeguarding.

6.4.1 Strengths and Limitations

The use of realist methods in the present review facilitated a focus on *'what works, for whom, and in what circumstances'* with regard to the implementation of adult safeguarding in NHS health services, using an interpretive / narrative approach (Pawson et al, 2004, p. 3). Through a process of data extraction, the chosen method helped identify factors that facilitate effective practice and associated barriers. However, due to the paucity of empirical research on the topic, it was not possible to determine the success or failure of the programme theory using evidence-based practice. In addition, the studies identified tended to focus on a singular area of adult safeguarding practice (e.g. staff training, multi-agency working); hence it was not possible to derive

conclusions about implementation approaches holistically. Nevertheless, this review is the first to examine the implementation of adult safeguarding in NHS health services within a realist framework.

6.4.2 Conclusion

The findings of this review indicate early resistance on behalf of NHS partners to engage with adult safeguarding initiatives and dilatory approaches to implementing strategies and practices within NHS services. Barriers were identified at a number of levels, including the attitudes of front-line staff members and the negation of senior managers to take ownership of their roles with adult safeguarding. While practice appears to have advanced considerably in some areas (e.g. staff training, involvement approaches, the establishment of safeguarding teams), concentrated efforts are focused on individual levels, with considerable oversight to others. In addition, structured approaches to the implementation of adult safeguarding that take a holistic view of the needs of the area are considerably lacking. There is a clear need for better scrutiny of adult safeguarding arrangements in NHS services to ensure that effective practice permeates all levels of the organisation. In the next chapter the findings of this review will be discussed in relation to the findings of the qualitative study reported in this thesis.

Chapter Seven: Discussion and Conclusion

Chapter Overview

The following chapter provides a general discussion of the research presented within this doctoral thesis. The chapter begins with explanation of how the research aims and objectives have been fulfilled, by way of an integrated discussion of the qualitative findings presented in Chapter 5, in relation to the literature reviewed in Chapter 1 and Chapter 6. This is followed by discussion of the strengths and limitations of this research, which are specifically related to its exploratory nature, methodological approach, and anticipated impact. The chapter continues by outlining the implications of the research and proposed recommendations for future practice. This is followed by discussion of the plans for dissemination and future research development. The chapter concludes with a précis of the key findings of this research.

7.1 Introduction

The aim of the present research was to explore the implementation, development, and use of adult safeguarding practices and procedures in NHS mental health services. A further aim was to improve understanding of the processes involved in keeping adults safe in mental healthcare and identify whether the challenges faced differ to those in alternative care settings. A variety of research activities were undertaken to explore this issue and have been discussed in detail throughout this thesis. In the upcoming sections, the research findings will be considered in relation to existing literature and the aims and objectives established at the outset.

7.2 Fulfilment of the Research Aims

An illustration of the conceptual framework derived from the findings of the qualitative study (see Chapter 5) is presented in Figure 7.1. Figure 7.1 documents the journey of three mental health trusts through the implementation, development and use of adult safeguarding practices and procedures. The figure depicts three conceptual components each of which is central to the implementation of adult safeguarding within the substantive area of mental health. The conceptual overview begins with the initial stages of implementation, where the establishment of structures, processes and procedures for effective practice is the predominant focus. Following on from this, the need to address and understand the specific challenges faced in mental health is recognised; and finally a transition to an increasingly more transparent outlook is observed within mental health services. Barriers invariably hamper the establishment of

effective practice throughout the process of implementation, some of which are specific to mental health contexts. This is an important consideration for the future development of customised approaches within specialist services. The findings indicate that progressive development in this area is contingent upon, effective leadership, robust strategies, and a transparent organisational culture.

The experiences of mental health services with regard to implementing adult safeguarding policy and practices are potentially not uncommon; however, extensive evidence suggests that the journey in mental health has been considerably more tumultuous (DH, 2008; DH, 2009; Whitelock, 2009). Proctor et al (2009), assert that implementation strategies must carefully consider the contingencies of specific service systems or practice settings, in relation to the characteristics of the implementation activities themselves, as these may or may not be conducive to successful implementation. The study findings highlight a potential discordance between generic multi-agency policy incentives and the organisational composition of NHS mental health trusts. In the next section, a discussion of the findings will be presented in accordance with the objectives established at the outset.

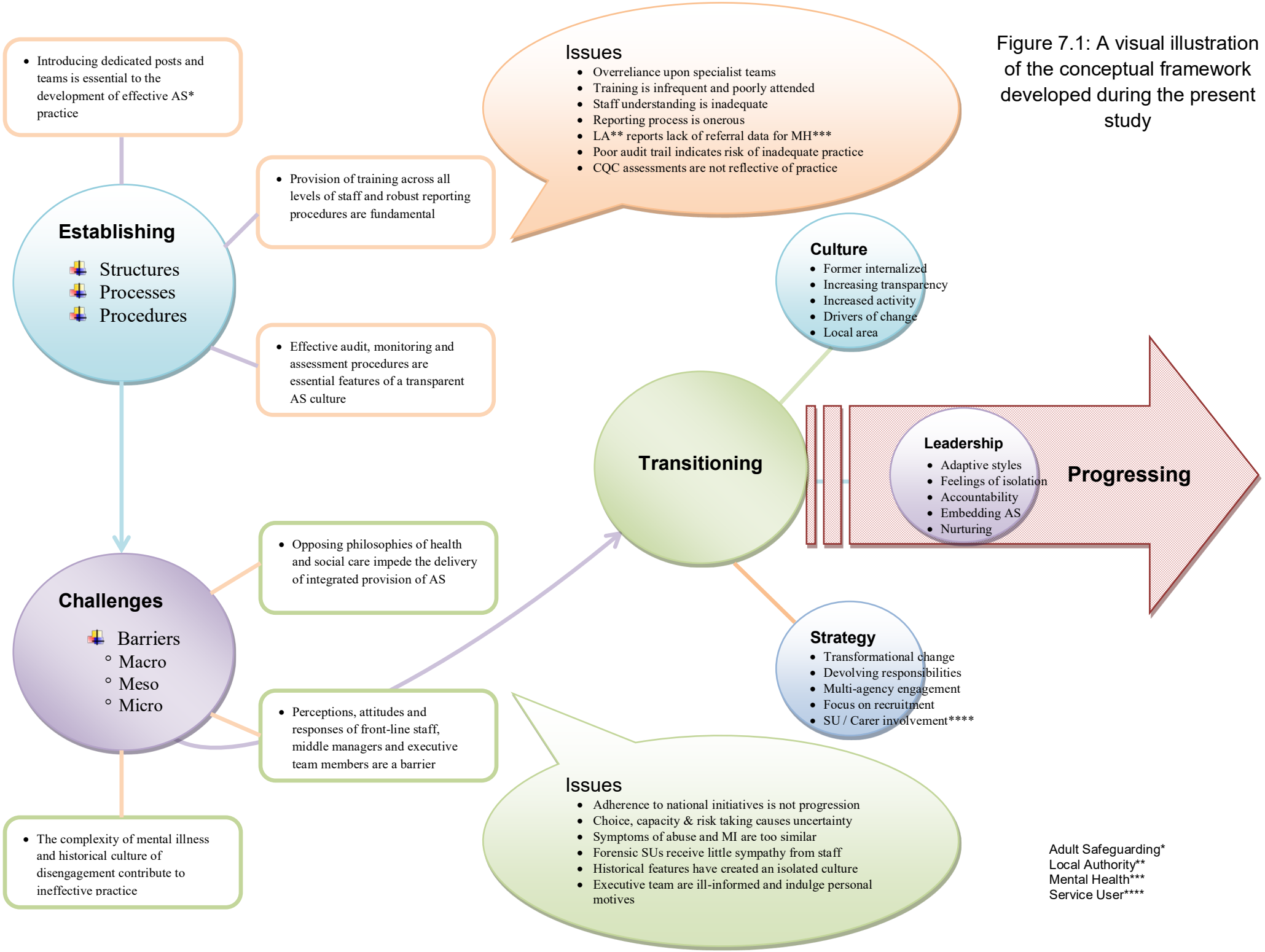


Figure 7.1: A visual illustration of the conceptual framework developed during the present study

7.3 Correspondence with the Research Objectives

7.3.1 Stakeholder experiences of implementation in NHS mental health services

The first objective of this research was to explore stakeholders' experiences and perspectives of implementing adult safeguarding within NHS mental health services. A structured approach to implementation underpinned by the core principles of empowerment, prevention, protection, proportionality, and partnership is recommended within existing literature (DH, 2011a, 2014). Participants emphasised the positive impact of dedicated posts and teams on adult safeguarding practice, albeit the potential for specialist roles to discourage staff from taking ownership was highlighted.

In accordance with national guidelines, participating trusts were routinely providing staff training tailored to the needs and requirements of safeguarding responsibilities associated with individual job roles. Indeed, the recommended Level 1 training for basic awareness was identified as compulsory for all staff (ADSS, 2005; DH, 2014). In addition, supervision was used to encourage reflective practice and multi-agency training opportunities were highlighted (ADSS, 2005; DH, 2014). Nevertheless, training was perceived as potentially tokenistic with an overemphasis placed upon achieving compliance, and inadequate time invested to yield the optimum benefit. Of further concern was a lack of evidence that training was positively impacting practice, which was indicated by continued inappropriate staff responses.

In contrast with recommendations for procedures that facilitate *'swift and personalised'* responses on behalf of staff members (DH, 2011a; DH, 2014, p.241), reporting processes were identified as onerous and bureaucratic. Efforts to simplify complicated reporting processes were viewed positively; however it was anticipated that such efforts would be met with resistance among senior staff members. A common theme within the literature is the tendency of NHS staff to prioritise the reporting of incidents that are recurrent, intentional and considered serious enough (Taylor & Dodd, 2003; McCreadie et al, 2008; Johnson, 2006; NPSA, 2006). The study findings echoed similar practices with responses revealing a tendency to deal with less serious incidents internally. Team performance with regard to generating referrals was also notably varied, with learning disability teams identified as better referrers. This is also consistent with existing literature which highlights that staff with more experience of safeguarding issues are more aware of their responsibilities (McCreadie et al, 2008; Fennell, 2016). The resulting impact of these issues was evident in the low number of referrals received by local authorities that were generated from within mental health services.

The need for governance systems that effectively audit and benchmark adult safeguarding practice is highlighted within existing literature (Arya & Callaly, 2005; DH, 2011). Despite efforts to establish effective governance arrangements for adult safeguarding in mental health trusts the findings revealed that practice in this area was careless and disorganised. In addition, there were considerable issues with a lack of viable benchmarks, and evidence of a potential misalignment between Care Quality Commission (CQC) requirements and the intended transparency of multi-agency

working. Such dichotomies have the potential to influence the under-reporting of incidents in favour of adhering to CQC expectations. Indeed, target focused approaches for the implementation of organisational policy are denoted for prioritising the needs and requirements of the organisation, thereby minimising the autonomous recognition of service users' needs (Newman, 2001; Galphin & Parker, 2007).

The findings of this research suggest that the implementation of adult safeguarding in NHS mental health services is disjointed. There have been concerted efforts to establish effective processes and procedures for adult safeguarding in line with national policy, advice and guidance. However, the findings are indicative of a translational gap between policy and practice, and highlight the need for greater consideration of the intricacies of service delivery within mental healthcare (Proctor et al, 2009). It is clear that at the time of data collection adult safeguarding was not fully embedded in mental health. Indeed implementation efforts were not having the impact required to ensure the delivery of effective adult safeguarding practice and the majority of barriers were associated with internal processes. The findings, thus, reflect concerns about the level of engagement in mental health services with the national adult safeguarding agenda (DH, 2008; DH, 2009, Whitelock, 2009). Nevertheless, the complexity of this issue is heightened by multiple organisational challenges, which must be considered prior to the development of future intervention strategies. The specific challenges to effective implementation revealed within the study findings will be discussed in the next section.

7.3.2 Perceived barriers to implementation in NHS mental health services

The second objective of this research was to identify the main barriers to the development of effective adult safeguarding practices in NHS mental health services. Indeed, failure to anticipate barriers and develop strategies for dealing with resistance significantly contributes to ineffective approaches to change within organisations (Ferlie & Shortell, 2001; Dopson et al, 2005). Existing literature identifies organisational culture as a relevant predictor of change and contexts that are service-user orientated are highlighted for their ability to prevent abuse and neglect (Dopson et al, 2005; Rycroft-Malone, 2010; Stevens, 2015). The findings of this research revealed a service-centred culture in mental health, which promoted isolated practices that were rooted in the legacy of former asylums. This resulted in a reluctance to report issues to external agencies and a tendency to problem solve, which was evidenced by the production of sub-standard documentation, the consequential termination of partnership agreements, and secretive internalised practices. Cultural issues such as these were particularly challenging from a leadership perspective and strategies adopted focused on working with staff to discourage collusive practices.

Acceptance of responsibility among staff members and willingness to uphold the six core principles of adult safeguarding within daily practices is essential to a culture that prevents abuse and neglect (NHS England, 2017; DH, 2011a, 2011b). The study findings revealed many barriers associated with staff attitudes and acceptance of responsibility for adult safeguarding in mental health, including: failure to recognise the applicability of adult safeguarding in mental health or within specific roles e.g. nurses; a

lack of understanding and appropriate action being taken; being overwhelmed by the circumstances of working in mental health; and feelings of resentment following an investigation. This is consistent with existing literature which highlights the inconsistency of staff responses to abuse incidents in mainstream health services where staff have disputed their responsibility for adult safeguarding, perceive procedures as burdensome and prioritise the needs of the service (Draper et al, 2009; Jenkins et al, 2007).

The proposed leadership structure for adult safeguarding highlights the need for clear lines of responsibility at multiple levels (NHS, England, 2017). However, a recurrent theme within existing literature was the disengagement of managers in mainstream health services during the early years of adult safeguarding implementation (Cambridge & Parkes, 2006). The present research similarly highlighted buy-in at the level of middle management as a barrier to implementation in mental health. Responses revealed issues with inadequate managerial support, delegation of duties to junior team members, and reluctance to accept responsibility. Engagement at the executive level was also identified as a barrier with similar issues observed, including: oversight to the need for safeguarding intervention, a disregard for expert advice, and prioritising personal and political agendas. Proposed recommendations for addressing such issues include the provision of specialist leadership training courses and specifying adult safeguarding responsibilities within job descriptions for managerial posts (Agnew, 2012; Draper et al, 2009).

The incongruous nature of the goals of health and social care services is well documented and existing literature identifies this longstanding conflict as a particular issue for multi-agency working (Galphin & Parker, 2007; McCreadie et al, 2008; Boardman, 2005). This is particularly evident within the present research, which identified numerous barriers to adult safeguarding associated with the integration of health and social care services. The particular issues identified included the use of different systems, conflicting views regarding which service has greater responsibility for adult safeguarding, and communication breakdown. However, divergence between the philosophical approaches used within health and social care disciplines was evidently of greater significance. Boardman (2005) notes the emergence of the medical-model for the treatment of mental illness using psychotropic drugs and the social care model, which focused on addressing the social problems associated with mental illness, during the 1980s. The study findings identified medical-model dominance as a particular barrier to adult safeguarding in mental health with safeguarding viewed as secondary to the medical needs of service-users. Nevertheless, responses indicated that the presence of social workers within integrated teams strengthened the overall provision of adult safeguarding, which was seen as a particular advantage.

The third objective, exploration of the specific circumstances associated with safeguarding adults with mental health difficulties, was identified as a barrier to practice and is therefore discussed in the present section. A recurring theme within existing literature is the ambiguity of professional decision-making within the context of adult safeguarding (Galphin & Parker, 2007; Williams, 2002). Evidence indicates that staff

members may develop their own interpretations of risk, experience difficulties with balancing individual rights and professional duties, and display a lack of skills to deal with such ambiguities in practice (Taylor & Dodd, 2003; Galphin & Parker, 2007; Williams, 2002; Fennell, 2016). This is consistent with the findings of the present research, which highlights difficulties with determining vulnerability related to patient-to-patient assault, as well as dilemmas associated with mental capacity and risk taking in mental health settings. Ethical decision-making is particularly challenging for practitioners and the inclusion of specialist training to prepare staff members for the eventualities of day-to-day practices was advocated by study participants.

Power differentials within social institutions are denoted for their negative impact on adult safeguarding due to the marginalisation of service-users who are deemed powerless in relation to the service provider (Williams, 1998; Williams & Keating, 2000; Whitelock, 2009). Indeed, evidence reveals a tendency of staff members to disregard or trivialise abuse reported by service-users in mental health settings and in some cases associate abuse allegations with the symptoms of mental illness (Williams, 1998; Williams & Keating, 2000; Whitelock, 2009). This is consistent with the present research, which highlights difficulties differentiating between the symptoms of mental illness and the symptoms of abuse. As a result, a service user's deteriorating mental health may be prioritised, resulting in the possibility of abuse or neglect as the underlying cause of symptoms being overlooked.

Existing literature further highlights the link between social inequalities and mental illness and the perpetuation of these within power structures such as NHS mental health services (Williams & Keating, 2000; Whitelock, 2009). The indifference of mental health professionals to the presence of such inequalities results in the replication of inequitable practices within services (Brown & Stein, 1997; Williams & Keating, 1999). This is consistent with the findings of the present research, which highlights the reluctance of service users to report abuse due to the potential for a disclosure to jeopardise their chances of being discharged. Indeed, the findings revealed that participants' experiences of staff responses to abuse incidents suggested that staff were less likely to believe reports of abuse that coincided with deteriorating mental health.

Furthermore, literature highlights the public fear of mental illness and a tendency of staff members to view psychiatric settings as a vestibule for public protection, thereby viewing inappropriate responses to abuse as justified (Galphin & Parker, 2007). The findings of the present study are indicative of inappropriate responses to abuse and neglect in forensic mental health settings. Indeed, responses revealed that service-users in forensic settings who have committed crimes, receive little sympathy from staff members if they are being abused. In addition, staff members adopt a more punitive approach with forensic service-users due to knowledge of their prior criminal history. It is essential that individuals with leadership responsibility for adult safeguarding directly challenge discriminatory practices such as these, to ensure that service users are adequately protected.

The findings of this research reveal considerable barriers to the development of effective adult safeguarding practice in NHS mental health services. Many of the barriers identified are rooted in historical issues within mental health and the NHS generally, which continue to impact contemporary healthcare provision. In addition, the findings indicate that the circumstances surrounding safeguarding adults in mental health settings are arguably more complex than mainstream services. Approaches to the implementation of adult safeguarding in mental health have evidently been top-down with a predominant focus on the enactment of government policy, advice and guidance, by strategic and operational personnel (Van Meter & Van Horn, 1975). The findings indicate that the already existing challenges within mental health have not been adequately considered within the development of plans for implementation. In the next section, additional points of comparison will be made between the findings of this research and the review of literature presented in Chapter 6.

7.3.3 Examining the evidence-base for adult safeguarding

The fourth and final objective of the present research was to review existing literature relevant to the implementation or development of adult safeguarding practice across NHS health services. The purpose of this activity was to examine existing evidence and identify factors that facilitate the effective implementation of adult safeguarding in NHS health services. Much of the literature reviewed has been discussed in the preceding sections to interpret the findings of the present research. This section will, therefore,

focus on interpreting the remaining key findings in relation to the literature and broader consideration of the evidence-base for adult safeguarding across the breadth of NHS services in comparison with mental health.

The realist review of literature presented in Chapter 6 revealed that a structured and co-ordinated approach to the implementation of adult safeguarding in health services is recommended, and practices should be integrated, patient-led, strategically embedded, responsive, vigilant, collaborative and multi-layered (DH, 2009, 2010a, 2010b, 2011a, 2011b, 2014). Similar to the findings of the present research, the review revealed widespread disengagement with adult safeguarding across NHS health services during the early years of implementation (Ramsay, 2009; Fennell, 2016). Indeed, examination of the literature revealed resistance among staff members, tolerance of patient-to-patient aggression, and negligent reporting practices (Fennell, 2016). Furthermore, consistent with the findings of the present research, the strategies used to improve practices and develop robust procedures across NHS health services have included the introduction of specialist teams, designated lead nurse roles for adult safeguarding, and enhanced training provision. In addition, the review revealed barriers to practice associated with organisational culture, ineffective leadership, difficulties achieving shared goals with multi-agency partners, and a lack of outcome measures for adult safeguarding (Taylor & Dodd, 2003; Draper et al, 2009; Cambridge & Parkes, 2006). Nevertheless, there is much that can be learned from the development of adult safeguarding practice within mainstream NHS services.

Innovation in the area of governance structures for adult safeguarding within mainstream services has seen the development of audit tools for use on wards, electronic systems for monitoring admissions in emergency care, and the use of risk assessment plans within care planning initiatives (Butler, 2004; Nash et al, 2010; Choi & Mayer, 2000; McCreadie, 2001; CSCI, 2008). Furthermore, issues with the alignment of goals across partnership organisations have been addressed through the development of joint investigation training models, which have received positive feedback (Cambridge & Parkes, 2006). There has also been considerable advancement in the development of strategies to enhance service-user and carer involvement with adult safeguarding practice in mainstream services. For example, literature highlights service-user involvement in investigations, the use of advocacy and support services, evaluating service user satisfaction levels with safeguarding, and qualitative exploration of service-user experiences (Cambridge & Parkes, 2006; Braye & Preston-Shoot, 2012; Wallcraft, 2012). This is of particular significance to the present research, as participant responses indicate that service-user involvement is an area that requires development in mental health.

Existing literature suggests that organisational change is a complex process that requires long-term investment (Stevens, 2015). The findings of the present research revealed evidence of an internalised culture in mental health, where staff members displayed a lack of ownership and compassion for the precarious predicaments of

service users'. Short-term improvements were evident within the study findings; however the ultimate goal for strategic leads for adult safeguarding is to influence significant long-term change to organisational culture in mental health. Stevens (2015) suggests that any change effort should consider the societal, organisational, and personal factors that impact adults at risk. In addition, a number of noteworthy facilitators of change are identified within existing literature, including: strong and effective leadership at all levels; buy-in from staff and recognition of the need for change; inter-personal characteristics of managers; practitioner flexibility with regard to organisational boundaries; and compatibility between the environment and the intervention (Agnew, 2012; Stevens, 2015; Cambridge & Parkes, 2006; Harbottle, 2007). Individuals with leadership responsibility for adult safeguarding in mental health services should incorporate the facilitators identified as a mechanism for cultural change.

Effective leadership is highlighted as essential to effective adult safeguarding practice and it is suggested that individuals at senior management level should focus on establishing a 'just' and open culture that is proactive accountable, collaborative and personalised (Agnew, 2012; Stevens, 2015). The findings of the present research revealed numerous professional and personal challenges experienced by senior strategic leaders for adult safeguarding in mental health. The challenges identified included: oversight responsibility for services that are beyond reach; feelings of isolation; pressures associated with being accountable; and motivation to ensure safeguarding is embedded. In response to the demands of their role in adult

safeguarding, senior leaders describe similar characteristics required to fulfil their duties, including: being adaptable, assertive and authoritarian, nurturing and supportive, and committed to the cause. Despite the considerable emphasis placed upon the need for effective leadership, there is a paucity of literature that considers the role of leadership with the implementation of adult safeguarding in NHS health services. Furthermore, participant experiences in the present research suggest that senior leaders require additional support and training to prepare them amply for this challenging task.

The realist review of literature undertaken for the present research revealed that the issues and challenges associated with the implementation of adult safeguarding in mainstream NHS health services are comparable with those experienced in mental health. More specifically, NHS health services were initially resistant to the implementation of adult safeguarding and experienced similar issues with ineffective leadership, organisational culture, multi-agency working, and unacknowledged abuse incidents. Despite a paucity of research that focuses on the implementation of adult safeguarding in NHS health services generally, there have been greater advancements within mainstream services than in mental health. It is, thus, proposed that innovative strategies utilised within mainstream services are adapted and customised to the needs and requirements of mental health services to improve adult safeguarding practice. Nevertheless, the literature review and study findings collectively indicate that adult safeguarding research in the NHS is considerably underdeveloped and in need of

immediate attention to sustain continued growth. In the next section the strengths and limitations of this research will be outlined.

7.4 Strengths and Limitations

The strengths of the present research are associated with the exploratory and applied nature of the research topic, the appropriateness and rigour of the methodological approach adopted, and the real-world implications of the research findings. The topic of adult safeguarding in mental health is a neglected phenomenon that lacks empirical or theoretical application of any kind. Given substantial evidence that mental health service users were experiencing abuse within inpatient settings, were not receiving adequate protection, and that mental health services were failing to engage with the adult safeguarding agenda, there was an immediate need for research. However, due to the absence of reliable benchmarks or outcome measures it was not possible to accurately measure the performance of mental health services in relation to adult safeguarding. In addition, much of the evidence offered within existing literature to substantiate the disengagement of mental health services with adult safeguarding was anecdotal, with limited knowledge derived from within the services themselves. This research, thus, contributes knowledge that was previously unavailable to improve understanding of the use of adult safeguarding in mental health, the compatibility of generic policies, advice and guidance with the intricacies of service delivery in mental health, and the challenges associated with resistance to change in mental health. In addition, this

research contributes to a wider body of knowledge regarding the use and implementation of adult safeguarding within NHS organisations.

A further strength of this research is the appropriateness of its methodological approach to the needs and requirements of the research area. As aforementioned, the research topic was unexplored with an overwhelming lack of empirical or theoretical application. Resultantly, it was necessary to utilise a range of scoping activities during the initial stages to acquire the information needed to develop appropriate research questions. The range of activities included a preliminary literature review (see Chapter 1), informal discussions with practitioners involved with safeguarding in mental health, and an online survey of mental health trusts in the UK (see Chapter 2). Due to the considerable lack of measurable data related to the research topic, collectively these activities accumulated substantial descriptive information with which to develop the study further. Pursuant to the needs of the research, the subsequent phase was positioned within the qualitative research tradition, with the aim of constructing a substantive theory of adult safeguarding grounded in the data collected in mental health. The rigour achieved through application of the Grounded Theory Method (GTM) facilitated the acquisition of substantive evidence with which to conceptualise the use and implementation of adult safeguarding in NHS mental health services (Charmaz, 2000, 2006, 2007). The methods and activities used throughout this research were selected pragmatically to maximise its responsiveness to the needs and requirements of the research area, which represents a particular strength of this research.

In addition to the strengths outlined, it is likely that this research will have a tangible impact on practice with the potential to improve mental health service users quality of life and experiences with services. The research highlights the need for services to take a proactive approach to the development of adult safeguarding practice that poses direct challenges to malpractice and inappropriate responses to abuse and neglect by staff members at all levels. It calls for the improvement of implementation strategies and the development of customised plans to ensure that adult safeguarding practices are compatible with the intricacies of mental health service delivery. It emphasises the need for better engagement with multi-agency partners and highlights the need to establish greater equilibrium between the social and medical aspects of mental illness within the context of adult safeguarding. It further, emphasises the impact of inequalities on mental health service users and the likely perpetuation of these within institutional settings within the context of adult safeguarding. It is anticipated that the findings of this research will influence improvements to future practice; thus the protection of service users will be improved, and service user experience will be enhanced with a likely consequential impact on overall quality of life and improvement to service user satisfaction levels.

Nevertheless, it is necessary to consider the limitations of this research, which are inadvertently related to the exploratory nature of the research topic and methodological approach adopted. More specifically, as with any qualitative inquiry the findings of this

research are not generalisable and as such the experiences and perspectives of the participants in this study are not representative of all NHS mental health trusts. Indeed, the findings of the survey carried out during the scoping phase revealed that trusts were at different stages of implementation; hence, it is quite likely that participants in different trusts will have different experiences of adult safeguarding. However, for the purpose of maximising the range of perspectives captured in this study the researcher purposively selected trusts at different stages of implementation using information gathered during the survey (see Chapter 4). It is, therefore, asserted that the findings of this research have broad relevance across NHS mental health services and can be used as a point of reference by trusts for the purpose of identifying areas of adult safeguarding practice that require improvement.

Sixteen participants took part in the qualitative study, which may also be viewed as a limitation. Contemporary qualitative studies commonly, and somewhat arbitrarily, feature between twenty to fifty participants to comply with increasingly stringent publication standards (Bryman, 2016). However, the aim of qualitative data collection in the present research was to reach theoretical sufficiency, which is consistent with the Grounded Theory (GT) approach adopted (Dey, 1999; Morse, 2007; Charmaz, 2006). Indeed, the emphasis in the present study was upon the quality of the data collected, which is considered superior to the number of participants it is gathered from (Charmaz, 2006). Furthermore, a requirement of participation in the qualitative study was involvement with the implementation of adult safeguarding; study participants were therefore required to have leadership responsibility for adult safeguarding. The findings

of the survey indicated that 93% of trusts had up to four individuals with leadership responsibility for adult safeguarding within their organisation (see Chapter 2). This demonstrates that the sixteen participants sampled across the three NHS mental health trusts in this study are representative of the target population. It is worth noting that while it was necessary to focus specifically on sampling individuals with leadership responsibility, this is potentially a further limitation. Indeed, the findings highlight many barriers to practice associated with the inappropriate responses of staff members; hence the findings may have been strengthened by the inclusion of front-line staff within the participant sample. The researcher asserts, however, that expansion of the participant sample in this way would inevitably have altered the parameters of the research and its aims and objectives. It is therefore suggested that exploration of the perspectives of front-line staff is a separate area of research that warrants future exploration.

7.5 Implications and Recommendations

The findings of this research have implications for the development of adult safeguarding practice in NHS health services. The findings specifically indicate misalignment between national adult safeguarding policy and guidance, and the intricacies of service delivery within NHS organisations. It is essential that intervention strategies for adult safeguarding take a holistic view of services with due consideration given to the societal, organisational, and personal factors that impact adults at risk. The findings suggest that a multi-layered approach is required to ensure that safeguarding is

embedded at the heart of the organisation. Furthermore, barriers are inevitable and must be pre-empted to ensure that change is achieved in the long-term.

The findings also have specific implications for the establishment of effective adult safeguarding practice in NHS mental health services. The anomalies of mental health service delivery enhance the complexity of delivering effective adult safeguarding practice. The findings highlight extensive areas that require improvement to ensure that practice development in mental health is on a par with other services. Mental health services should focus specifically on: developing staff competencies in the area of ethical decision-making; the provision of specialist training to middle-managers to avoid blocks at this level; decreasing bureaucracy by simplifying reporting processes; challenging discriminatory attitudes, complacency, and collusive practices; improving ownership at senior and executive levels; providing better support to strategic leaders of adult safeguarding; better recognition and integration of social care models; recognition of social inequalities and power differentials and the impact of these on practice; and promoting safe and secure environments that support service users to raise concerns without fear of reprisal. To facilitate a trust-wide approach in this endeavour, it is recommended that NHS mental health trusts embrace the concept of personal leadership, empowering staff to develop their own strategies for incorporating adult safeguarding within their routine practices (Sturmberg & Martin, 2012).

It is worth noting that some time has lapsed since data collection ceased in 2013 and the continuing relevance and contribution of this work must be considered. As discussed in Chapter 1 and Chapter 6, *No Secrets* (DH, 2000) was the first official guidance document made available to services for the purpose of implementing adult safeguarding practices. A review of progress was subsequently published in 2009 in the *Consultation on the Review of the No Secrets Guidance* (DH, 2009) with specific reference to the lack of engagement observed in mental health. Since the commencement and completion of research interviews for this study two key publications have emerged: *Care and Support Statutory Guidance: Issued under The Care Act* (DH, 2014); *Safeguarding Adults: a Guide for Healthcare Staff* (NHS England, 2017). These were examined in Chapter 6 and incorporated within the discussion of theoretical drivers intended to support the successful implementation of adult safeguarding in NHS health services presented in section 6.2.2.

The most significant developments to practice guidelines since *No Secrets* (DH, 2009) include: the legal requirement for a Safeguarding Adults Board (SAB) in each Local Authority (LA); the establishment of information sharing agreements with partnership organisations; and improved approaches for involving service-users, carers and family members in healthcare processes. As such, it is likely that practices in these areas have improved in mental health services since 2013; however, during the systematic searches conducted for this study, few published studies were found that examined practice development in mainstream NHS services and none for mental health. In addition, the review of literature presented in Chapter 6 demonstrates that this is a slow

moving area of development and as aforementioned, organisational change requires long-term investment (Stevens, 2015). The researcher therefore asserts that the findings of this study remain of considerable importance to the development of adult safeguarding practice in NHS mental health services and are essential to reflective learning.

7.6 Dissemination and Future Development

The publication plans for this research include two empirical papers: one which will be based upon the realist review of literature presented in Chapter 6 and the other based upon the GT study presented in Chapter 5. One empirical paper has already been published and is available to view online[28]. The researcher anticipates one other publication, a discussion piece based upon the historical background of abuse and neglect in mental health, discussed in Chapter 1. The findings of this work will also be disseminated at relevant research conferences and NHS trust seminars. In addition to the dissemination plans outlined, the findings highlight a number of areas that require future research development. In view of the inappropriate responses of staff members to adult safeguarding highlighted throughout this research, there is a clear need for exploration of the perspectives and experiences of front-line staff members in relation to adult safeguarding in mental health.

[28] Please follow attached link for published paper https://doi.org/10.3109/09638237.2013.775406

In addition, the findings indicate a need for exploration of the knowledge and awareness of staff members in relation to the impact of social inequalities and power differentials on mental health service users and the potential impact of these on adult safeguarding within services. Investigation into adult safeguarding practices in forensic mental health settings is paramount, specifically in response to the inappropriate staff attitudes and unsavoury practices highlighted in this study. The findings also indicate a need for further investigation into the leadership of adult safeguarding across the breadth of NHS health services, and identification of the factors needed to better support those who are at the forefront of the safeguarding plan. Finally, the trial and implementation of theoretically informed and customised interventions for the enhancement of adult safeguarding practices within NHS organisations and NHS mental health trusts is essential to sustain continued progress in this area.

Conclusion

This research explored the use and implementation of adult safeguarding practices and procedures in NHS mental health services. Driven by the methodological needs of the research area, it utilised a Grounded Theory (GT) approach to develop a substantive theory of adult safeguarding in three NHS mental health trusts. The findings indicate that concerted efforts have been made to establish effective processes and procedures for adult safeguarding in mental health in line with national recommendations. Evidence highlights resistance to adult safeguarding in mental health and mainstream NHS services during the initial years following the publication of the *No* Secrets (DH, 2000) guidance. The study findings demonstrate that resistance remains prevalent and strategic and operational leaders for adult safeguarding face considerable challenges to overcome existing barriers. Efforts to address these issues should be multi-dimensional and take particular consideration of the specific challenges faced in mental health, including: the presence and impact of inequalities on mental health service users; diversification of the goals of health and social care; and the need for direct challenges to malpractice in historically collusive environments. This research demonstrates a need for the development of strategies that anticipate the contingencies of service contexts and greater consideration of the factors that inevitably impact adults at risk across healthcare services.

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Appendices

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Appendix 1a

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Appendix 2a

Informal Discussion Questions

1. Are you the dedicated Safeguarding Lead practitioner and how long have you been in post?
2. Is this your only job or is it an addition to another role?
3. How many people work on your team?
4. What type of trust do you work for i.e. Mental health, LD, Children's services?
5. How many trusts do you support?
6. What types of intervention have you used for staff training around the area of safeguarding?
7. Were staff receptive and do you think your intervention was effective?
8. What could have been done differently that may have improved its effectiveness?
9. In your trust – how do staff react to the concept of safeguarding?
10. What do you feel are the main issues around the area of safeguarding currently?
11. Do you think these barriers can be overcome and if so how?
12. How do you feel about multi-agency working and how does this concept work for your trust? Do they hold Safeguarding Conferences?
13. If I were to design a survey on-line would it get through your security systems? Surveymonkey.com
14. Do you object to the use of the information given during the discussion for the purposes of informing the survey questionnaire?
15. Does your trust have a customized safeguarding policy?
16. How do the personnel policies affect the safeguarding policies? Do they overrule them when it comes to abuse and neglect?

Appendix 2b

Survey Fast Track Ethical Approval

Updated 16.12.08

STAFFORDSHIRE UNIVERSITY
FAST-TRACK ETHICAL APPROVAL FORM (STUDENTS)

Tick one box: ☐ TAUGHT POSTGRADUATE project ☐ UNDERGRADUATE project
☑ PhD/MPhil project ☐ TAUGHT POSTGRADUATE MODULE assignment
☐ TAUGHT UNDERGRADUATE MODULE assignment
☐ Other project (Please state ... ...)

Title of Course on which enrolled ... ...MPhil / PhD... ... ...

Tick one box: Full-Time Study ☑ or Part-Time Study ☐

Title of project ... ... Safeguarding adults in mental health survey ... ...

Name of student researcher ... ... Tina Fanneran ... ...

Address: ... ...Centre for Ageing and Mental Health, Faculty of Health, Blackheath Lane ... ...

Name of supervisor/module tutor ... ...Professor Paul Kingston; Professor Eleanor Bradley ... ...

Student Researchers- please note that certain professional organisations have ethical guidelines that you may need to consult when completing this form.

Supervisors/Module Tutors - please seek guidance from the Chair of your Faculty Ethics Committee if you are uncertain about any ethical issue arising from this application.

		YES	NO	N/A
1	Will you describe the main procedures to participants in advance, so that they are informed about what to expect?	X		
2	Will you tell participants that their participation is voluntary?	X		
3	Will you obtain written consent for participation?	X		
4	If the research is observational, will you ask participants for their consent to being observed?			X
5	Will you tell participants that they may withdraw from the research at any time and for any reason?	X		
6	With questionnaires and interviews will you give participants the option of omitting questions they do not want to answer?	X		
7	Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	X		
8	Will you give participants the opportunity to be debriefed i.e. to find out more about the study and its results?	X		

If you have ticked **No** to any of Q1-8 you should complete the full Ethics Approval Form.

		YES	NO	N/A
9	Will your project deliberately mislead participants in any way?		X	
10	Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort?		X	
11	Is the nature of the research such that contentious or sensitive issues might be involved?		X	

If you have ticked **Yes** to 9, 10 or 11 you should complete the full Ethics Approval Form. In relation to question 10 this should include details of what you will tell participants to do if they should experience any problems (e.g. who they can contact for help). You may also need to consider risk assessment issues.

Faculty of Health/Sciences Fast Track Students
Helen Sutton
16/12/08

Appendix 2c

Default Question Block

In.
'Safeguarding Adults' in Mental Health Survey

My name is Tina Fanneran and I am currently undertaking my PhD at Staffordshire University. Although my PhD is in its very early stages, it will broadly focus on 'Safeguarding Adults' in mental health services, for which it is hoped your trust will provide vital information. The following explains in more detail why this survey is being carried out and what it will involve for your trust. It is therefore important that you take the time to read it carefully, before consenting to take part.

Purpose of the survey
'Safeguarding Adults' is described as the 'range of activity aimed at upholding an adult's fundamental right to be safe. It is of particular importance for people who, because of their situation or circumstances, are unable to keep themselves safe.' Although there has been a national commitment to support 'Safeguarding Adults' work, the availability of existing research that highlights best practice with regard to its implementation and development is limited; particularly in mental health services. Therefore, this survey aims to gather useful information about current 'Safeguarding Adults' activity in all mental health trusts across England and Wales; to aid the development of research questions that will be of national benefit.

Why has your trust been chosen?
Your trust is being invited to take part as it has been identified as one of 83 trusts across England and Wales that provides services to individuals suffering from mental ill health.

Is Participation Compulsory?
No! Participation is entirely voluntary and your trust may withdraw at any time. However, the success of this survey depends upon the willingness of potential participants to contribute.

Is the survey confidential?
All information gathered during this survey will remain strictly confidential, accessed only by the researcher. In the interest of providing a means for withdrawal of data you will be asked to provide your trust's contact details. Following data collection all trust names will be removed to maintain anonymity. The survey results will be grouped then analysed and potentially published at a later date.

In order to convey the real-life application of 'Safeguarding Adults' work at your trust we would like to use quotes at random from the responses given, for which you or your trust will not be identifiable.

How do I withdraw?
You may withdraw your data at any time by e-mailing the researcher with the contact details of your trust at the e-mail address listed below. Please note following publication withdrawal of data will not be possible.

Filling out the questionnaire
You will be asked to fill out a short questionnaire, which will take approximately 15 minutes to complete. You are advised to read each question carefully before responding.

It is hoped that the information provided above clearly answers any questions you may have about this survey. However, should you have any further queries or require additional information, please do not hesitate to contact the researcher using the contact details listed below.

Researcher Contact Details
Miss Tina Fanneran
Centre for Ageing and Mental Health
Staffordshire University
Blackheath Lane
Stafford
ST18 0AD
00 44 (0)1785 353742
T.Fanneran@staffs.ac.uk

In.
Instructions

Thank you for agreeing to complete this survey on 'Safeguarding Adults'.

You are encouraged to complete each section ensuring all questions are answered.

If a question appears irrelevant, insert N/A next to it.

As this survey is specifically interested in 'Safeguarding Adults' in Mental Health services, it would be best completed by a person who is responsible for safeguarding or has extensive knowledge of its structure within your trust.

Q1.
Section 1 - Consent

Please provide your trust's contact details.

Name	
Address 1	
Address 2	
Address 3	
Address 4	
Address 5	
Postcode	

Q2. I have read and understand the information provided for this survey.

- ○ Yes
- ○ No

Q3. I fully understand that my trust's participation in this survey is voluntary.

- ○ Yes
- ○ No

Q4. I understand the withdrawal procedure.

- ○ Yes
- ○ No

Q5. I have been given the opportunity to ask questions.

- ○ Yes
- ○ No

Q6. I consent to the use of anonymous quotes from my responses.

- ○ Yes
- ○ No

Q7. I would be interested in participating in future focus groups / one-to-one interviews to discuss my views on 'Safeguarding Adults' in mental health services.

- ○ Yes
- ○ No (contiue to section 2)

Q8. If you have given consent to be contacted by the researcher for future research participation, please provide your name and contact details.

Name	
Address 1	
Address 2	
Address 3	
Address 4	
Postcode	
Telephone No.	
Email Address	

S2.
Section 2 - This section is about the organisational structure of 'Safeguarding Adults' at your trust.

Section 2A - The 'Safeguarding Adults' substantive post.

Q1. Does your trust have a substantive post for 'Safeguarding Adults'?

- ○ Yes (Complete this section).
- ○ No (Continue to section 2B).

Q2. What is the official title of this post? (e.g. 'Safeguarding Adults' lead).

Q3. Which band is he / she paid under?

Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9
☐	☐	☐	☐	☐	☐	☐

Q4. How long has this post been active within your trust?

- ☐ Up to 1 year.
- ☐ 1 to 2 years.
- ☐ 2 to 4 years.
- ☐ 4 years or more.

Q5. Please select the 'Job Type' relevant to this post.

- ○ Permanent
- ○ Temporary

Q6. Please select the 'Working Pattern' relevant to this post.

- ○ Part-time (up to 18.75 hrs per week)
- ○ Full-time (up to 37.5 hrs per week)
- ○ Other [ ]

S2B. Section 2B - This section is about individuals who share leading responsibilities for 'Safeguarding Adults' at your trust.

Q1. Please tell us how many people share leading responsibilities for 'Safeguarding Adults' at your trust.

- ○ 2
- ○ 3
- ○ 4
- ○ Other [ ]

Q2. What are their official titles?

Person No. 1	[ ]
Person No. 2	[ ]
Person No. 3	[ ]
Person No. 4	[ ]
Person No. 5	[ ]

Q3. Please select the bands under which they are paid.

	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9
Person No. 1	○	○	○	○	○	○	○
Person No. 2	○	○	○	○	○	○	○
Person No. 3	○	○	○	○	○	○	○
Person No. 4	○	○	○	○	○	○	○
Person No. 5	○	○	○	○	○	○	○

Q4. Please give a percentage estimate of how leading responsibilities are divided? (the total percentages given must add up to 100)

Person No. 1 [0]

[0]

Person No. 2	0
Person No. 3	0
Person No. 4	0
Person No. 5	0
Total	0

Q5. In general are these responsibilities secondary to an existing job?

- ○ Yes
- ○ No

Q6. In addition to 'Safeguarding Adults' responsibilities, do the person's named above have safeguarding responsibilities for other 'Vulnerable Groups'?

- ○ Yes
- ○ No

Q7. Does your trust have future plans to introduce a dedicated subtantive post for 'Safeguarding Adults'?

- ○ Yes
- ○ No

Q8. If you have any additional comments or would like to tell us about future plans for the leadership of 'Safeguarding Adults' at your trust, please use the space provided.

S2C. Section 2C - This section is about members of staff that are directly / indirectly involved with 'Safeguarding Adults'.

Q1. Does your trust have a Safeguarding Team i.e. are there other dedicated safeguarding roles in addition to the substantive 'Safeguarding Adults' post?

- ○ Yes
- ○ No

Q2. Please provide the titles of additional members of the Safeguarding Team. (e.g. Administrator, Child Safeguarding Lead Practitioner etc).

No. 1

No. 2

No. 3

No. 4

Q3. Including all contracted hours of staff who are directly reponsible for 'Safeguarding Adults', approximately how many contracted working hours are designated to 'Safeguarding Adults' duties per week?

- ○ Up to 20
- ○ Up to 40
- ○ Up to 60
- ○ Up to 80
- ○ Other

Q4. Does your trust have a substantive post for 'Safeguarding Children'?

- ○ Yes
- ○ No

Q5. If your trust does not have a safeguarding team, are there plans to introduce additional dedicated safeguarding roles in the future?

- ○ Yes
- ○ No

Q6. In terms of trust wide integration with safeguarding, are there members of staff whose safeguarding responsibility indirectly contributes to 'Safeguarding Adults' practice e.g. information sharing etc.

- ○ Yes
- ○ No

Q7. Please use this space to tell us about future plans for extending the safeguarding team at your trust and staff members who indirectly contribute to 'Safeguarding Adults' practice.

S3. Section 3 - This section is interested in how 'Safeguarding Adults' awareness is generated and monitored at your trust.

Q1.
What levels of staff undergo mandatory 'Safeguarding Adults' training at your trust?

You may make more than one selection

Bands 1 through 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9
☐	☐	☐	☐	☐	☐	☐	☐

Q2. **Which of the following interventions have been used to generate 'Safeguarding Adults' awareness among staff at your trust?**

- ☐ Lunch time seminars.
- ☐ Promotional literature.
- ☐ Customised SG Adults training.
- ☐ Other

Q3. **In addition to initial safeguarding training, are staff at your trust provided with regular updates and safeguarding refreshers to maintain momentum?**

- ○ Yes
- ○ No
- ○ Other

Q4. **Which of the following interventions have been used to generate 'Safeguarding Adults' awareness among service users at your trust?**

- ☐ Promotional Literature.
- ☐ One-to-One Consultation.
- ☐ Word of Mouth
- ☐ Other

Q5. **Do staff and service users have 24-hour access to 'Safeguarding Adults' information?**

- ○ Yes
- ○ No

Q6. **Which of the following methods are used to monitor staff practices with regard to 'Safeguarding Adults' work?**

- ☐ Clinical Supervision
- ☐ Appraisal
- ☐ Point raised at team meetings.
- ☐ Other

Q7. Does your trust produce an annual report on 'Safeguarding Adults' work?

- ○ Yes
- ○ No

Q8. How many years has your trust been producing this report?

Q9. Does your trust use a computerised reporting system to collect and monitor information around protection issues?

- ○ Yes
- ○ No

Q10. Please use this space to tell us about alternative interventions or additional activity used to promote 'Safeguarding Adults' at your trust. We are also interested in the interventions you found most effective and why?

S4.
Section 4 - This section is interested in your views on 'Safeguarding Adults' practice at your trust.

Some of the questions ask that you simply indicate the extent to which you agree or disagree with the statements given, while others ask that you expand your answer providing as much detail as possible.

Q1. The combined number of working hours dedicated to 'Safeguarding Adults' duties at my trust, is sufficient time to complete all tasks effectively.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
○	○	○	○	○	○

Q2. Staff at my trust appear to have embraced the concept of 'Safeguarding Adults'.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
○	○	○	○	○	○

Q3. Please use this space to explain in more detail how staff have received 'Safeguarding Adults' at your trust. We are also interested in hearing about any existing barriers to safeguarding at your trust.

Q4.
Increasing media attention focussing on safety issues in mental health settings (e.g. Rowan Ward, 2003; Mind, 2004; NPSA, 2006; Mind, 2007) -

A) Has heightened 'Safeguarding Adults' awareness at my trust.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
○	○	○	○	○	○

Q4. B) Has had a negative impact on 'Safeguarding Adults' practice at my trust.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
○	○	○	○	○	○

Q5. Prior to the introduction of the 'No Secrets' guidance and the 'Safeguarding Adults' national framework; the protection of adults with Mental Health difficulties was largely overlooked at my trust.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
○	○	○	○	○	○

Q6. Please state at least three key triggers that have prompted improved 'Safeguarding Adults' practice at your trust (e.g. No Secrets guidance, Serious Untoward Incident at my trust etc.).

No. 1
No. 2
No. 3
No. 4

Q7. Please use this space to further explain the triggers you have identified above, providing as much detail as possible.

S5. Section 5 - This section is about Multiagency Partnership.

Q1. Does your trust have an individual with responsibility for 'Safeguarding Adults' at Executive Board level?

- ○ Yes
- ○ No

Q2. What is his / her official title?

Q3. Which band is he / she paid under?

Bands 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9
○	○	○	○	○	○

Q4. Is he / she in a senior management position at your trust?

- ○ Yes
- ○ No

Q5. Does your trust submit an annual report on 'Safeguarding Adults' work to the Executive Board?

- ○ Yes
- ○ No

Q6. Does your trust have a representative on the local area 'Safeguarding Adults' Partnership who has a clear line of responsibility back into the organisation?

- ○ Yes
- ○ No

Q7. Does your trust have a customised 'Safeguarding Adults' Policy?

- ○ Yes
- ○ No

Q8. Does the customised 'Safeguarding Adults' policy feed into the 'Safeguarding Adults' Multi-agency policy?

- ○ Yes
- ○ No

Q9. Please use the space below to insert on-line links to both the 'Safeguarding Adults' Multi-agency Policy within your locality and your trust's customised policy. Alternatively you may e-mail the documents directly to T.Fanneran@staffs.ac.uk quoting the name of your trust.

S6.
Section 6 - This final section is interested in any differences between 'Safeguarding Adults' with Mental Health difficulties and 'Safeguarding Adults' with Learning Disabilities at your trust.

It should only be completed if your trust is combined with other services i.e. Learning Disabilities, Child Services etc.

Q1. The time required to carry out duties for 'Safeguarding Adults' with Mental Health difficulties is considerably less than the time needed for 'Safeguarding Adults' with Learning Disabilities.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
○	○	○	○	○	○

Q2. It is easier to make decisions about issues concerning the safety of adults with Mental Health difficulties than it is for adults with Learning Difficulties.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
○	○	○	○	○	○

Q3. Please use this space to tell us about any differences between 'Safeguarding Adults' with Mental Health difficulties and 'Safeguarding Adults' with Learning Disabilities at your trust.

Appendix 3a

The five-question method for framing a qualitative research study

Five-Questions to select the "color" to paint a qualitative design (McCaslin & Wilson-Scott, 2003)

Question to Act to Discover Preferred Approach	**Associated Tradition**
1. If I could discover the meaning of one person's lived experience, I would ask _____ (individual) about _____.	Biography
2. If I could discover the shared lived experiences of one quality or phenomenon in others, I would want to know about _____.	Phenomenology
3. If I could experience a different culture by living/ observing it, I would choose to experience _____.	Ethnography
4. If I could discover what actually occurred and was experienced in a single lived event, that event would be _____.	Case Study
5. If I could discover a theory for a single phenomenon of living as shared by others, I would choose to discover the theory of_____	Grounded Theory

Appendix 3b

List of Figures

Appendix 4a

Open-ended survey responses

Trust	Qualitative Response
T1	There is more work to be done in mental health because of the lack of awareness – we are where we were in LD services 6 or 7 years ago. There seems to be an assumption that people with LDs are more vulnerable hence the greater referral levels. I think that attitudes to risk are different between LD & MH workers with LD workers being more cautious. In both fields I feel we need to improve our understanding of a) vulnerability & risk b) mental capacity & consent.
T2	Some passionate that it is good practice others more interested in domestic abuse. Barriers – staff may be working with people who make repeated decisions that put them at risk, working with perpetrators makes it harder to raise issues of abuse when victim isn't the service user, plus issues of service users have made unfounded allegations against staff. Particular problem reported is when service user does not give consent to share information within therapeutic relationship.
T3	It is harder to look at issues of capacity within adults with mental health issues as they swing between states of capacity and incapacity across a wide range of issues is apparent. The difficulty with working with people with learning disabilities is the misconception that they cannot take risk or don't have the capacity to make a decision over things like sexual relationships.
T4	We are a mental health and learning disability trust, safeguarding is applied across the whole organisation equally. Some of our learning disability staff have more experience of safeguarding.
T5	We have a system of "Safeguarding Lead Managers" – these individuals attend our 6-weekly Safeguarding Group meetings. Their roles involve disseminating information down to their teams and bringing any important issues to the Safeguarding Group. A future development will be to have "safeguarding champions" in each clinical area. These individuals will be the front line staff for safeguarding who will take a lead on practice issues around safeguarding. They feed information to the Safeguarding Lead Managers in their clinical areas and vice-versa. The Senior Matron will also be able to liaise directly with the safeguarding champions, ensuring that any information pertinent to practice is sent to them for cascade to other staff.
T6	Increased numbers of referrals from both in inpatient and community sectors. Some barriers are that 'old school' staff that used to work in 'asylums' feel that safeguarding is covered if the service users have a roof over their heads. We are working hard to change these attitudes and challenge at every opportunity!! We have a stamp out stigma campaign, which is helping to change these attitudes.

Appendix 4b

Safeguarding Adults Draft Interview Schedule

The following presents a guide of the potential questions with prompts and probes that will be used during interviews, which participants will be encouraged to discuss in detail. It is expected that this will become more refined and focused as data collection progresses. Additionally, it is not anticipated that this schedule will be strictly adhered to, as this would limit the potential to explore other interesting areas and experiences.

Introduction: outline of research study, confidentiality / anonymity, tape-recording, withdrawal, protocol for disclosure of sensitive information

Warm up Questions

1. What is your job title?

2. What are your responsibilities?

3. Length of time served in current post?

4. Tell me about your involvement with adult safeguarding?
   Prompt How much responsibility / time allotted / day to day activity

5. In terms of your professional experience of safeguarding practice, can you explain what safeguarding adults means to you?
   Prompt understanding of adult safeguarding / personal view / what it means at this trust / how important is it?

Implementation

6. Can you tell me how safeguarding adults has been implemented at this trust?
   Prompt How has it been rolled out?
   Probe What strategies have been used / staff interventions – detail

7. What staff interventions worked well and why?

8. In your opinion have staff members at this trust fully embraced adult safeguarding?
   Probe can you identify any particularly hard to reach groups

9. What strategies have been used to ensure that service users are aware of their right to be safe / protected?
   Probe Any identified difficulties with these strategies, how could they be improved?

Practice

10. Can you tell me about the adult safeguarding practices and procedures currently operating at this trust?
    Prompt reporting procedures / lines of reporting / what happens on a day-to-day basis?

11. In terms of current practices and procedures, what works well and why?
    Prompt examples of good practice

12. What historical / current practice and procedural issues exist?
    Probe How are these dealt with?
    Examples of solutions
    Are they effective?

13. What other embedded practices and procedures overlap with safeguarding practices and procedures?
    Prompt personalised care, risk assessment, mental capacity assessments, best interest decision
    Probe can you tell me about how overlaps such as these are dealt with

14. How would you describe the organisational attitude to adult safeguarding at this trust?
    Prompt (positive, negative, apathetic, given high priority)
    Probe any observable changes during your time working here, any differences in attitude between different staff groups?

15. Can you describe any incidents / initiatives, historical or otherwise, that have influenced change to organisational attitudes / attitudes of specific groups to safeguarding adults?
    Prompt specific incidents involving staff / service users, in-house trust initiatives

16. Can you describe the main barriers to adult safeguarding at this trust?
    Probe What specific obstacles are faced when attempting to safeguard adults with mental health difficulties?

17. Can you describe the specific obstacles faced when attempting to safeguard adults with mental health difficulties?
    Prompt anything that you would describe as difficult only when protecting adults with mental health difficulties?
    Capacity
    Therapeutic Relationship

18. How would you rate existing adult safeguarding practices at this trust? 1 to five (high)
    Prompt to provide adequate protection for service users, enhance staff awareness, enhanced feelings of being safe and secure

Policy

19. Can you explain your involvement with the development of the safeguarding adults policy at this trust?
    Prompt What specifically is your contribution to the development of this policy?

20. How does the policy work in practice?
    Prompt day-to-day practical application / understood by staff at the front-line / is it strictly adhered to?
    Probe What procedure is used to gain feedback about its applicability?

21. How is understanding and awareness of policies and procedures measured / examined?
    Prompt Staff / Service Users

22. How are decisions made about different elements of the policy?
    Prompt procedure / who's involved / who makes the final / ultimate decision

Personal Views

23. In your view how important is it for service users to feel safe and protected whilst in trust care?

24. Some researchers suggest that traditionally mental health services have been reluctant to tackle the problem of abuse?
    Prompt would you agree with this suggestion?
    Probe would you say this is still the case?

25. Some people suggest that it is easier to ensure that children and adults with learning difficulties are protected than adults with mental health difficulties, any views?

26. Some researchers suggest that existing safeguarding practices and procedures limit the rights of services users with mental health difficulties, any views?

27. What are your views on personalisation?
    Probe do you think there is potential for it to be embedded within existing safeguarding practices for the future?

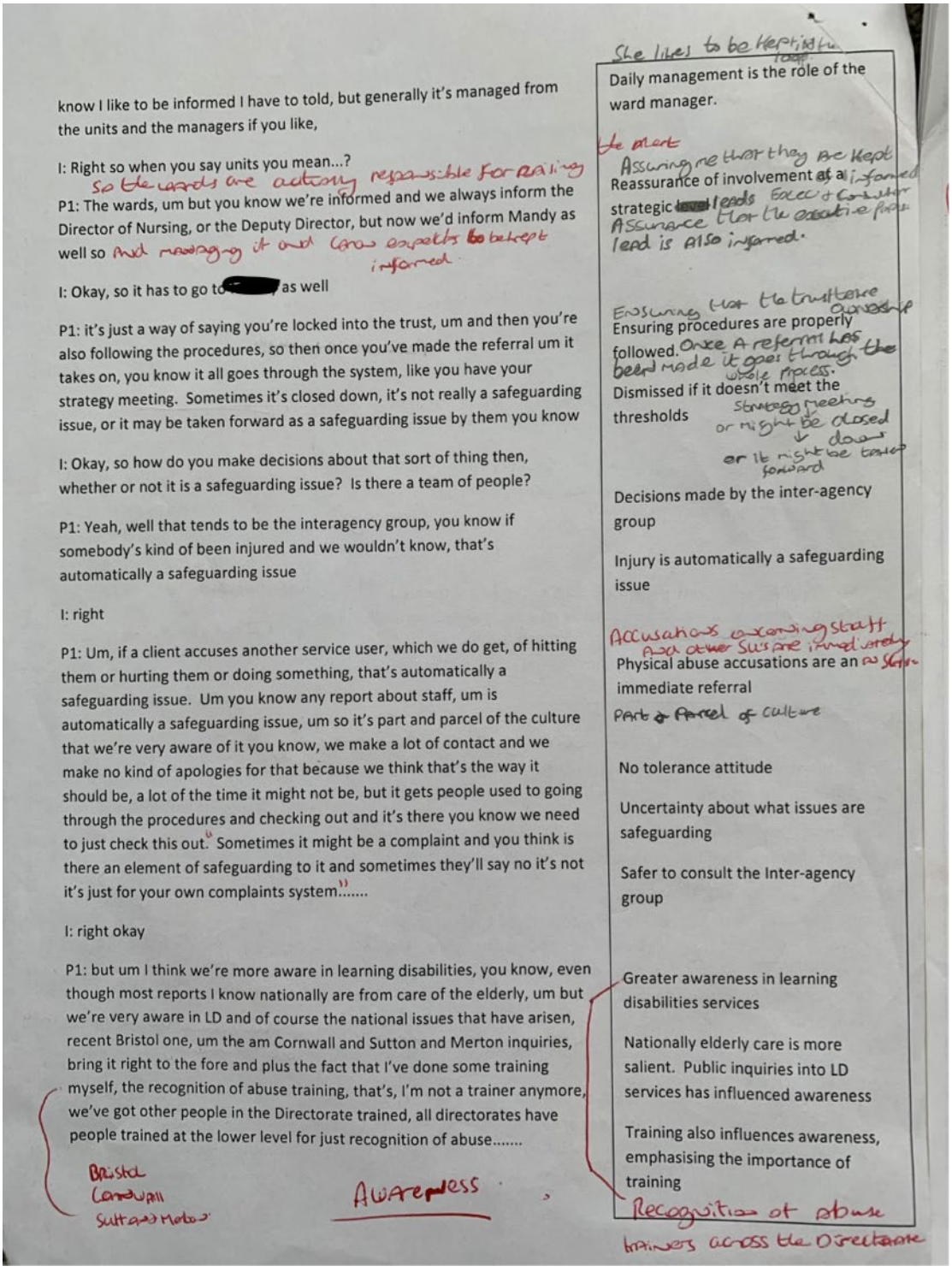
28. In your opinion what improvements should be made to adult safeguarding practices at this trust?
    Probe what strategies should be used to action these changes / improvements

29. What three words best describe adult safeguarding practice at this trust?

30. Is there anything else you'd like to discuss / add?

Appendix 4c

Coding Sample A



know I like to be informed I have to told, but generally it's managed from the units and the managers if you like,

I: Right so when you say units you mean...?

P1: The wards, um but you know we're informed and we always inform the Director of Nursing, or the Deputy Director, but now we'd inform Mandy as well so

I: Okay, so it has to go to [redacted] as well

P1: it's just a way of saying you're locked into the trust, um and then you're also following the procedures, so then once you've made the referral um it takes on, you know it all goes through the system, like you have your strategy meeting. Sometimes it's closed down, it's not really a safeguarding issue, or it may be taken forward as a safeguarding issue by them you know

I: Okay, so how do you make decisions about that sort of thing then, whether or not it is a safeguarding issue? Is there a team of people?

P1: Yeah, well that tends to be the interagency group, you know if somebody's kind of been injured and we wouldn't know, that's automatically a safeguarding issue

I: right

P1: Um, if a client accuses another service user, which we do get, of hitting them or hurting them or doing something, that's automatically a safeguarding issue. Um you know any report about staff, um is automatically a safeguarding issue, um so it's part and parcel of the culture that we're very aware of it you know, we make a lot of contact and we make no kind of apologies for that because we think that's the way it should be, a lot of the time it might not be, but it gets people used to going through the procedures and checking out and it's there you know we need to just check this out." Sometimes it might be a complaint and you think is there an element of safeguarding to it and sometimes they'll say no it's not it's just for your own complaints system....."

I: right okay

P1: but um I think we're more aware in learning disabilities, you know, even though most reports I know nationally are from care of the elderly, um but we're very aware in LD and of course the national issues that have arisen, recent Bristol one, um the am Cornwall and Sutton and Merton inquiries, bring it right to the fore and plus the fact that I've done some training myself, the recognition of abuse training, that's, I'm not a trainer anymore, we've got other people in the Directorate trained, all directorates have people trained at the lower level for just recognition of abuse.....

Daily management is the role of the ward manager.

Reassurance of involvement at a strategic [redacted] level

Ensuring procedures are properly followed.

Dismissed if it doesn't meet the thresholds

Decisions made by the inter-agency group

Injury is automatically a safeguarding issue

Physical abuse accusations are an immediate referral

Part & Parcel of culture

No tolerance attitude

Uncertainty about what issues are safeguarding

Safer to consult the Inter-agency group

Greater awareness in learning disabilities services

Nationally elderly care is more salient. Public inquiries into LD services has influenced awareness

Training also influences awareness, emphasising the importance of training

Coding Sample B

issues and I think she's trying to get her head around what she can do to help the process. So if you're on an older adult ward or in a community mental health team for older adults, you have to generate the incident form, but then you have to speak to the district teams. And the district teams generate the AP1. So we don't get copies.....we're totally out of the loop with it really, unless um there is something that is a specific concern. You know say for example if it was um an older adult nurse going into establishment and it was obvious that there was institutional abuse going on, you know with that severity, we would all get a little bit twitched about that and want to know a bit more. But generally.....

I: so if it was more severe, you may get feedback, but the lesser sort of concerning incidents, you might not receive any feedback?

P2: yeah that's right....and [redacted]nd I are fairly confident that we can't be sure that we've got the actual, um that we know about all the VA's.

I: right

P2: so there's a two tier system in a way

I: okay, and is that different do you know to how it's structured in other trusts or districts?

P2: I don't know to be honest. I think if very much depends on whether or not the community mental health teams. It depends on whether or the social workers are integrated within the community mental health teams and I think in a lot of areas nationally, community mental health teams have evolved to have those social workers within the teams. Whereas in older adults, I don't think it's ever come to fruition. And now we're going to functional teams, so that it's an ageless service, so you're going to get....I mean we're going through a huge change over the next few months and our older adult teams will be disbanded and the functional element of the older adults will come into the main team.

I: right, okay so will you perhaps get some of that ownership back?

P2: well that depends because the social workers within the teams are still only commissioned to work with people under 65, right....so the referrals for vulnerable adult for people who are over 65 would still be looked after by the district teams and until that is reconciled – you know until you've got that critical mass of people from the district teams, which are looking after people with mental health problems in the community mental health teams, I'm not sure that we're going to be able to reconcile that.

I: so, what sorts of difficulties does this present for you then in terms of I guess monitoring?

P2: Well I mean you know, with the adult teams or the current teams that are under 65 teams, then there is relative confidence that not only do the teams know how they're dealing with VA issues because the social workers within the teams are obviously those that are dealing with the VA's and other members of the teams that have been trained in progressing investigations and you know everybody is sort of like sat on a strategy meeting. I think there's a development of competence and confidence, so you've got that at local level and then at our level, we can say on any given day really,

Comment [3]:
Process
- Older Adults
  - If it was severe e.g. institutional abuse, they would receive more information

Process (monitoring)

- Concern about whether or not they are monitoring all incidents involving VAs properly

Social Work / Social Care (the importance of integration)

- The structure of the process is dependent upon whether or not social workers are integrated within the teams
  - This is better in CMHTs
  - Never happened in Older Adult services
- Structural changes will have a further negative impact (functionalisation)

- Social Workers only commissioned to work with people under the age of 65
  - Referrals for over 65s will still only be looked at by district teams

Process (monitoring)

- For adults under 65 there is confidence that procedures are followed
  - Attributed to SW looking after VAs and VA referrals

⇦Use Quote

Appendix 4d

Categories, subcategories, and codes (incident & In-vivo) pre-narrative integration

No.	Category	Subcategory	Codes (Trust 1)	Codes (Trust 2)	Codes (Trust 3)	Codes In-Vivo (T1)
1	***Implementing adult safeguarding and establishing effective practice***	Roles, responsibilities and accountability	• Dedicated roles bring expertise	• Understanding practitioner / individual level responsibility • Implementing new roles	• Over-reliance upon one post / person • Over-reliance on SG team • Director level responsibility • Understanding practitioner / individual level responsibility	
		Training and supervision *'I think training is always the answer, but I'm not sure it's always the solution'*	• Types and levels of training • Fundamentals of success • Benefits of training • Supervision / training are equally important • Achieving compliance and box-ticking • Uptake of multi-agency training	• Types and levels of training • Fundamentals of success • Lack of meaningful benchmarks • Supervision is equally important as training • Current provision is insufficient	• Time limited delivery • Is training effective in practice • Training isn't working *'people don't get it'*	*-Confidence (staff)* *-The health way* *-They're not getting it* *-Ticking boxes* *-Compliance*
		Audit and Monitoring	• Sloppy record keeping • CQC assessment isn't indicative of performance • Finding out what people don't know • Lack of meaningful benchmarks • Government data is unusable • No service level data about number of referrals • Supervision as a means to audit	• Difficulty obtaining referral activity from LA • Focus on whole spectrum of care • Evidence of trilogy of risk • Sloppy record keeping • Supervision as a means to audit • Focus on reduction in timescales for investigation • Audit case files monthly	• Incorporate the views of patients and carers • Test staff understanding of SG	
		Recruitment ***'You know, when I see a person and they never really seem 100% in the way they approach me'***	• Look for moral values • Interviews and DBS checks aren't fool-proof • Instinct and intuition • Involving SUs in recruitment and selection			
		Reporting ***'if you report everything, it's going to look like you've got more reports, so you've got to be cautious with the figures as well'*** ***'you know, you'd clog up the system***	• Criterion for an immediate referral • Referrals are always expected • Being cautious about figures • Thresholds • Not enough referrals for size of the area	• Scrutinising SUIs for SG incidents • Encouraging staff to make referrals • Hyper-sensitive vs sensitive and sensible	• Providing staff with information about referral criteria • More referrals for older adults and younger adults with LD or PD • LA not receiving referrals due to other processes being used	*-Onerous*

		with that kind of thing'	• A complicated reporting process • Hyper-sensitive vs sensitive and sensible • Lack of outcome data for MH Trust • LA not receiving the required documentation • Issues with staff understanding and awareness		• Mostly complex cases being referred • Strategies for improving the process	
		Assessment	• Should be based upon: o Structures and processes o The presence of an annual report o Staff knowledge o Cases involving staff o Patient on patient cases o Repeated issues o Not referrals	• Challenge is how to qualitatively assess that you've made a difference • Not referrals • Combination of quant and qual	• NRLS system inaccurately reflecting SG incidents • CQC don't understand the NRLS system • CQC expectations don't comply with multi-agency arrangements	
		Multi-agency partnerships	• Safety is reliant upon multi-agency contribution • Advocating the development of a County establishment • Engaging multi-agency partners	• Importance of being perceived as a committed partner • LA reports good representation from MH • Positive impact of long-standing relationships • Good relationship with CQC	• Importance of sharing information • Problems retrieving referral data from LA • Council acting as regulator impedes partnership working • Good multi-agency connections at senior level	
2	***Culture***	Classifications of SG culture	• Healthy / Positive SG culture • Transparent vs collusive	• Healthy / Positive SG culture • Transparent vs collusive • Protective / Defensive	• Protective / Defensive • A culture of mental health	*-Part and parcel* *-Everybody's business* *-Feels right* *-Impenetrable*
		Then and now: promoting cultural change ***'I found it all incestuous. I found it so closed, isolating and I couldn't understand why we weren't working with that agency down the road or you know'***	• National Inquiries promote cultural change • Lack of engagement / ownership • Improved SG culture	• National Inquiries promote cultural change • Lack of engagement / ownership • Improved SG culture	• Lack of engagement / ownership • Improved SG culture • Resistance remains prevalent • Steps to eradicate resistance	*-Language of SG* *-Raising awareness* *-Engagement* *-Motivating* *-Fixed* *-Isolated* *-Secretive* *-Incestuous* *-New people in the driving seat* *-Got rid of the old thinking*
		Impact of 'Culture Area' on SG		• Unique local culture and trends	• Poor performance locally	*-faces stay*

		'If it's not high up on somebody's agenda, politically there's not necessarily the attention paid to it that it might require'		• Barriers exist	• Bias towards local political agenda	
		Barriers to cultural change	• Challenging staff attitudes • Hard to reach groups		• Avoidance behaviour • Lack of understanding / recognition • Hard to reach groups	
3	***Leadership***	Performance within Teams / Services	• Performance issues in teams • Factors that influence performance • Greater awareness in LD services • Abuse arising in LD services due to poor standards	• Performance issues in teams • Factors that influence performance • Greater awareness in LD services • LD are better at reporting	• Performance issues in teams • Factors that influence performance	*-Confidence* *-Competence*
		Leadership style		• Transactional vs transformational	• Transactional and transformational	*-velvet glove vs iron fist*
		Leadership challenges ***'yes, but people are scared, they're scared of safeguarding'***	• Staff responses to accusations / investigations • Importance of being proactive • Staff competence	• Inexperience – services • Inexperience – organisation • Accepting responsibility • Lack of understanding • Being isolated	• Overwhelming amount of work • Lack of understanding • Complexity of service delivery in large organisations	*-Respond swiftly* *-Sensitive*
		Middle managers	• Insufficient contributions • Accepting responsibility • Positive influence of proactive managers	• Positive relationship between middle-management at the Trust and the LA		
		Executive Level Support	• Lack of knowledge at the executive level • New roles are required	• Lack of buy-in at executive level • Insight demonstrated more recently • Exec directors are supportive	• Executive directors are supportive • Lack of exec level board representation	
		Strategies for Improvement		• Service-user / Carer involvement • Embedded in its widest sense • Importance of vigilance	• Promoting a culture of SG • Promoting discussion • Lead nurse roles – promising • Devolvement of levels of management	*-A critical gaze*
5	***Challenges to successful implementation***	Social Work vs Health ***'when you think of social workers you think of protection…there is more sort of the understanding of the system'***	• Organisation / structure of the services • Increased competence of SWs • Issues with communication • Advocating segregation of the services	• Advocating integration • Positive influence of SW in healthcare • Differing philosophical approaches • Dominance of the medical	• Segregation vs integration • Increased competence of SWs • SWs exposed to 'health' customs become conditioned • Dominance of the medical model	*-They just don't get it*

			• SW not valued / recognised in health • Differing philosophical approaches • Dominance of the medical model	model	• Differing philosophical approaches	
		Delivering SG within MH services is a complex and nuanced process ***'signs and symptoms of abuse are exactly the same as signs and symptoms of mental ill health'***	• Debates and Dilemmas • More abuse in MH • Impact of a multi-disciplinary approach • Experiences of abuse and SMI • Historically disengaged • Tendency to view allegations as related to / caused by MI • Evidence of disengagement / performance • Overemphasis on compliance • Minimum standards are acceptable	• Debates and dilemmas • Repeated allegations in MH • Expertise of MH professionals • Disadvantages for MH service-users • Public perception of MI • Historically disengaged	• Debates and dilemmas • Difficulties for MH service-users • MH specific advantages • SG is not embedded • Tendency to view allegations as related to / caused by MI • Evidence of disengagement / poor performance	*-Back covering exercise* *--Taking it seriously*
6	***Barriers and facilitators of Success***	Hard-to-reach groups / areas ***'I think in terms of forensic teams… the door was firmly closed'***		• Difficulties embedding AS within high secure services • Complications within offender health due to only being responsible for health provision	• The importance of asking the right questions • Learning from SCRs and SUIs • Communication campaigns	

Appendix 4e

Participant Information Pack

Information Sheet

Address of research site
Telephone number of research site

A critical analysis of adult safeguarding practices in NHS mental health services

Participant Information Sheet

Introduction
My name is Tina Fanneran and I am currently undertaking my PhD at Staffordshire University. The focus of my PhD research is the development, implementation and use of adult safeguarding practices and procedures in mental health services. I would like to invite you to take part in my research study; however before you make your decision you need to understand why this research is being carried out and what it will involve. It is therefore important that you take the time to read the following information carefully before consenting to take part.

What is the purpose of this study?
Safeguarding adults is described as the 'range of activity aimed at upholding an adult's fundamental right to be safe. It is of particular importance for people who, because of their situation or circumstances, are unable to keep themselves safe'. Although there has been a national commitment to support safeguarding adults work, the availability of research that highlights best practice with regard to its development, implementation and use is limited, particularly in mental health services. It is the aim of this research to explore existing adult safeguarding practices in NHS mental health trusts in England.

Why have I been asked to take part in the study?
You have been identified as someone who has knowledge of or is directly / indirectly involved with implementing adult safeguarding practices at a strategic or operational level within your trust. It is expected that a total of twenty-four participants will take part in this study

Do I have to take part?
Participation is entirely voluntary - it is up to you to decide to join this study. If you agree to take part, you will be asked to sign a consent form. You may withdraw from this study at any time, without giving a reason.

What will happen to me if I take part?
This study involves participating in a one-to-one interview with the researcher, which will last for between sixty to ninety minutes. Your interview will be audio recorded, for which you will be asked to provide consent. It is not expected that you will be asked to meet with the researcher on a second occasion; however the researcher requests that you remain contactable whilst your data is being analysed (up to eighteen months) in the event that aspects of your interview may need further clarification / exploration.

What will I have to do?

You will be invited to discuss your experiences of adult safeguarding practices and procedures within your trust. A guide to potential topics for discussion is available on request. At the end of the interview you will be given the opportunity to discuss your participation including your thoughts and feelings about the interview questions.

Where will the research take place?
Interviews will be carried out within your work place away from your clinical setting in a room suitable for conducting an interview.

What are the possible benefits of taking part?
This study will provide you with the opportunity to discuss your views on adult safeguarding. This information has the potential to enhance the future practice of adult safeguarding in mental health trusts across the U.K.

Will my participation be kept confidential?
All information, which is collected, about you during the course of this research will be kept strictly confidential. Throughout the study access to personally identifiable data will be restricted to the researcher and her supervisory team. All audio-recorded interviews and transcripts will be anonymously filed in locked storage in the Centre for Ageing and Mental Health at Staffordshire University. Following completion of the study raw data will be destroyed and anonymised interview transcripts will remain in locked storage within the Centre for Ageing and Mental Health. In order to demonstrate the reality of safeguarding in practice we would like to use anonymous quotes at random from your interview responses. You will be given the opportunity to review your interview transcript for errors.

What happens if I disclose something that may need reporting?
If there is a cause to discuss cases of abuse or neglect within your service to emphasise a point, anonymity of all parties concerned must be maintained. If unreported information regarding the abuse or neglect of a service user is disclosed during interviews this information will be shared with your line manager.

How do I withdraw?
You may withdraw from this study at any time by contacting the researcher using the details listed below with your name and contact details. Please note following the submission of a manuscript for publication the withdrawal of data will not be possible.

What will happen to the results of this study?
The data gathered during this study will be grouped, then analysed and submitted for publication at a later date in relevant journals. It is also anticipated that the findings of this study will be disseminated through oral presentations delivered at seminars and conferences.

What if there is a problem?
If you have concerns about any aspect of this study, you should contact the researcher using the details provided, who will endeavour to answer your questions. If you remain unhappy and wish to complain formally you can do this through the (*Insert Trust Name*) (http://www.nhs.uk/choiceintheNHS/Rightsandpledges/complaints/Pages/NHScomplaints.aspx) Complaints process by contacting the services liaison department on (*Insert Tel No.*).

What will happen if I am harmed during this research?
In the event that something does go wrong and you are harmed during this research, due to someone's negligence, then you may have grounds to take legal action for compensation against Staffordshire University or (*NHS Trust*), but you may have to pay your legal costs.

Who has reviewed this study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by the West Midlands Research Ethics Committee.

Thank you for taking the time to read this. It is hoped that the information provided above clearly answers any questions you may have about this study. However, should you have any further queries or require additional information, please do not hesitate to contact:

Researcher Contact Details
Miss Tina Fanneran
Centre for Ageing and Mental Health
Staffordshire University
Blackheath Lane
Stafford
ST18 0AD

Further Information and Contact Details
Research in the Centre for Ageing & Mental Health
http://www.staffs.ac.uk/faculties/health/research/camh/

This research is funded by Staffordshire University

Consent Form

Title of Study: A critical analysis of adult safeguarding practices in NHS mental health services

REC ref: **11/H1208/7**

Name of Researcher: Tina Fanneran

Participant number:

Please initial box

1. I confirm that I have read and understand the Patient Information Sheet dated 03.03.11 (version 3.2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical or legal rights being affected. ☐

3. I understand that individuals from Staffordshire University or from the NHS Trust may look at relevant sections of data collected during the study, where it is relevant to my taking part in the research. I give permission for these individuals to have access to my study records. ☐

4. I understand that interviews will be recorded and that anonymous direct quotes from the interview may be used in the study report and may be used in subsequent publications. ☐

5. I agree to the use of audio recording ☐

6. I would / would not like to receive summary of results from this study ☐

9. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent *(If different from Principal Investigator)*	Date	Signature

2 copies: 1 for participant, 1 for the project notes

Letter of Invitation Mental Health Trusts

Miss Tina Fanneran
Centre for Ageing and Mental health
Faculty of Health
Staffordshire University
Blackheath Lane
Staffordshire
ST18 0AD

Date:

Dear Sir / Madam,

My name is Tina Fanneran and I am currently undertaking my PhD at Staffordshire University in the area of adult safeguarding.

In June 2010 a national survey was distributed to all NHS mental health trusts in the U.K. to gather information about the development, implementation and use of adult safeguarding practices and procedures in NHS mental health services, in which your trust participated. When completing the survey a person with responsibility for adult safeguarding at your trust registered his / her interest in future research in this area. I am now in a position to move forward with my research study and I am once again inviting your trust to take part.

In order for your trust to participate it would be necessary for the researcher to have an initial consultation with the safeguarding lead practitioner at your site to identify individuals considered pertinent to the implementation of adult safeguarding within your trust. The researcher would continue to consult with the safeguarding lead practitioner for the duration of this study.

It is estimated that a maximum of four individuals within your trust would be identified to participate. Participants would be required to take part in a one-to-one interview with the researcher, which would last for between sixty to ninety minutes during work time. In order to carry out interviews the researcher would require access to a room considered suitable for this purpose.

I have enclosed copies of draft interview materials and information and consent sheets for your perusal. If you are interested in this research or require further information about this study, please contact the researcher using the details listed below.

Yours sincerely,

_____
Tina Fanneran

Researcher Contact Details
Miss Tina Fanneran
Centre for Ageing and Mental Health
Staffordshire University
Blackheath Lane
Stafford, ST18 0AD

Appendix 4f

REC Approval Letter

National Research Ethics Service
West Midlands Research Ethics Committee
Prospect House
Fishing Line Road
Enfield
Redditch B97 6EW
Chairman: Mr Paul Hamilton
Co-ordiantor: Nicola Murphy

Telephone: 01527 582 533
Facsimile: 01527 582 540

07 March 2011

Miss Tina Fanneran
Centre for Ageing and Mental Health
Faculty of Health, Staffs Uni
Blackheath Lane, Staffordshire
ST18 0AD

Dear Miss Fanneran

Study Title: **A critical analysis of adult safeguarding practices in NHS mental health services**
REC reference number: **11/H1208/7**

Thank you for your letter of 04 March 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the

study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*	
Protocol	3.1	17 January 2011	
Response to Request for Further Information	email	04 March 2011	
Letter of invitation to participant	3.1	17 January 2011	
Investigator CV		10 January 2011	
Supervisor CV - Professor Paul Kingston		01 November 2005	
Participant Consent Form	3.2	03 March 2011	
Interview Schedules/Topic Guides	3.1	17 January 2011	
REC application		13 January 2011	
Participant Information Sheet	3.2	03 March 2011	
Certificate of indemnity		01 July 2010	

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

11/H1208/7	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Nicola Murphy
Committee Coordinator
For and on behalf of
Mr Paul Hamilton
Chair

Email: nikki.murphy@westmidlands.nhs.uk
Enclosures: "After ethical review – guidance for researchers"

Copy to: *Professor Paul Kingston*
Centre for Ageing & Mental Health
Faculty of Health
Blackheath Lane
Staffordshire University
Stafford
ST18 0AD

R&D Department
Staffordshire University
Blackheath Lane
Stafford
ST18 0AD

R&D Sample Go Ahead Letter

Ms Tina Fanneran
Centre for Ageing and Mental Health
Faculty of Health
Staffordshire University
Blackheath Lane
Staffordshire ST18 0AD

Dear Tina

Study title: Safeguarding Vulnerable Adults in NHS Mental Health Services

We have considered your application for access to patients and staff from within this Trust in connection with the above study.

On behalf of the Trust the Lead Officer for Research Governance, and the Responsible Care Professionals within the Directorate have now satisfied themselves that the requirements for Research Governance, both Nationally and Locally, have been met and are happy to give approval for this study to take place in the Trust, with the following provisos:

- That all researchers coming into the Trust have been issued with either a letter of access or honorary contract by ourselves
- That you conform to the requirements laid out in the letters from the REC dated (07 March 2011), which prohibits any changes to the agreed protocol
- That you keep the Trust informed about the progress of the project at 6 monthly intervals
- If at any time details relating to the research project or researcher change, the R&D department must be informed.

Your research has been entered into the Trust database and will appear on the Trust website.

As part of the Research Governance framework it is important that the Trust are notified as to the outcome of your research and as such we will request feedback once the research has finished along with details of dissemination of your findings. You will be asked to provide a copy of the final report and receive an invitation to present final feedback via our research seminar series. To aid dissemination of findings, copies of final reports are placed on our Trust Website. To this end, please contact me towards the completion of the project to discuss the dissemination of findings across the Trust and a possible implementation plan.

If I can help in any other way please do not hesitate to contact me.

Yours sincerely

IPR Approval Letter

STAFFORDSHIRE UNIVERSITY

Faculty of Health

Staffordshire University
Blackheath Lane
Stafford ST18 0AD
United Kingdom

+44 (0) 1785 353766 (Enquiries)
+44 (0) 1785 353673 (fax)
www.staffs.ac.uk

To whom it may concern

Application for Independent Peer Review Approval

Researcher: **Tina Fanneran**

Study Title: **A critical analysis of adult safeguarding practices in NHS mental health services**

I can confirm that Staffordshire University supports this research project proposal being put forward by the above research project applicant, and that the University is willing to act as sponsor of the project if it received LREC approval.

Our support for this project takes account of the outcome of an independent peer review of its scientific merit undertaking within the University.

I can also confirm that the University has generic indemnity/insurance arrangements in place as stated on the attachment to this letter, that arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed, that arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts and that the duties of sponsors set out in the NHS Research Governance Framework for Health and Social Care will be undertaken in relation to this research.

Dr Jim Radcliffe
Chair,
University Academic Ethics Sub-Committee

Appendix 6a

Definitions and Classifications of Abuse and Neglect

The Care Act (2014)

Physical Abuse: including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.

Domestic Violence: including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence.

Sexual Abuse: including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

Psychological abuse: including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

Financial or material abuse: including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Modern slavery 181: encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

Discriminatory abuse: including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.

Organisational abuse: including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to ongoing ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

Neglect and acts of omission: including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

Self-neglect: this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

Incidents of abuse may be one-off or multiple, and affect one person or more. Professionals and others should look beyond single incidents or individuals to identify patterns of harm, just as the Care Quality Commission, as the regulator of service quality, does when it looks at the quality of care in health and care services. Repeated instances of poor care may be an indication of more serious problems and of what we now describe as organisational abuse. In order to see these patterns it is important that information is recorded and appropriately shared.

Patterns of abuse vary and include:

- Serial abusing in which the perpetrator seeks out and 'grooms' individuals. Sexual abuse sometimes falls into this pattern as do some forms of financial abuse;

- Long-term abuse in the context of an ongoing family relationship such as domestic violence between spouses or generations or persistent psychological abuse; or
- Opportunistic abuse such as theft occurring because money or jewellery has been left lying around.

Domestic abuse:

In 2013, the Home Office announced changes to the definition of domestic abuse:

- Incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse... by someone who is or has been an intimate partner or family member regardless of gender or sexuality
- Includes: psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence; Female Genital Mutilation; forced marriage.
- Age range extended down to 16.

Many people think that domestic abuse is about intimate partners, but it is clear that other family members are included and that much safeguarding work that occurs at home is, in fact is concerned with domestic abuse. This confirms that domestic abuse approaches and legislation can be considered safeguarding responses in appropriate cases.

Financial abuse:

Financial abuse is the main form of abuse by the Office of the Public Guardian both amongst adults and children at risk. Financial recorded abuse can occur in isolation, but as research has shown, where there are other forms of abuse, there is likely to be financial abuse occurring. Although this is not always the case, everyone should also be aware of this possibility.

Potential indicators of financial abuse include:

- Change in living conditions;
- Lack of heating, clothing or food;

- Inability to pay bills/unexplained shortage of money;
- Unexplained withdrawals from an account;
- Unexplained loss/misplacement of financial documents;
- The recent addition of authorised signers on a client or donor’s signature card; or
- Sudden or unexpected changes in a will or other financial documents.

Appendix 6b

Types and Levels of Recommended Training

The Care Act (2014)

The SAB should ensure that relevant partners provide training for staff and volunteers on the policy, procedures and professional practices that are in place locally, which reflects their roles and responsibilities in safeguarding adult arrangements. This should include:

- Basic mandatory induction training with respect to awareness that abuse can take place and duty to report;
- More detailed awareness training, including training on recognition of abuse and responsibilities with respect to the procedures in their particular agency;
- Specialist training for those who will be undertaking enquiries, and managers; and, training for elected members and others e.g. Healthwatch members; and
- post qualifying or advanced training for those who work with more complex enquiries and responses or who act as their organisation's expert in a particular field, for example in relation to legal or social work, those who provide medical or nursing advice to the organisation or the Board.

Training should take place at all levels in an organisation and be updated regularly to reflect best practice. To ensure that practice is consistent - no staff group should be excluded. Training should include issues relating to staff safety within a Health and Safety framework and also include volunteers. In a context of personalisation, boards should seek assurances that directly employed staff (e.g. Personal Assistants) have access to training and advice on safeguarding.

Training is a continuing responsibility and should be provided as a rolling programme. Whilst training may be undertaken on a joint basis and the SAB has an overview of standards and content, it is the responsibility of each organisation to train its own staff.

Appendix 7

MPhil to PhD Transfer Approved

TINA FANNERAN

(via e-mail: t.fanneran@staffs.ac.uk)

14 December 2011

Dear Tina

MPhil to PhD registration transfer application – approved 13 December 2011

With reference to your research degree transfer interview which took place on 12 December 2011 in the Faculty of Health, I am pleased to inform you that the Chair of the University Research Degrees Sub-Committee has today ratified the following recommendation submitted by the MPhil/PhD Transfer panel:

Recommendation:

i) ***The candidate's registration is transferred from MPhil to PhD.***
(Recommendations as to reconsiderations of minor aspects of the project can be conveyed to the candidate and supervisor by the transfer panel and need not impede transfer. Note: No written recommendations were recorded, but the panel wished to congratulate you on your performance in the interview and on the submission of a thorough and well-written progress report.)

Your successful transfer from MPhil to PhD registration is now officially approved and your records will be amended accordingly to show you are now registered for the degree of PhD as a full-time student.

Please observe the minimum and maximum periods of registration as detailed in the research degree regulations for submission of your thesis.

On behalf of the Committee, I wish to take this opportunity to wish you continued success with your research project.

Yours sincerely

LINDA EYRE
Research Awards Officer

Tel: (01785) 353846
l.c.eyre@staffs.ac.uk

cc: Principal Supervisor - Professor Paul Kingston
Faculty Administrator - Helen Sutton