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Pike, Lindsey Anne

**Award date:**  
2012

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NOT JUST TICKING THE BOX: AN INVESTIGATION INTO SAFEGUARDING  
ADULTS TRAINING TRANSFER IN CORNWALL, UK

by

LINDSEY ANNE PIKE

A thesis submitted to the University of Plymouth  
in partial fulfilment for the degree of

DOCTOR OF PHILOSOPHY

School of Social Science and Social Work  
Faculty of Health



Lindsey Anne Pike

Not just ticking the box: An investigation into safeguarding adults training transfer in

Cornwall, UK

## Abstract

Safeguarding adults is a priority in adult social care, and training is one of the main ways in which policy and guidance around it is implemented. Training transfer refers to the use of new learning on the job, and while the transfer literature is well developed, it does not extend to safeguarding adults training. This research aimed to identify, develop and refine a programme theory of safeguarding adults training transfer by identifying factors that facilitate or inhibit the use of safeguarding adults training in practice, and the impact that the training has.

A cross sectional mixed methods realist synthesis approach was used to evaluate two safeguarding adults training programmes provided in Cornwall, UK between 2009 and 2011. Realist synthesis aims to uncover what works, for whom, in which circumstances and how, and develops policy makers' programme theories of interventions using evidence. A systematic review of training transfer generally, and then of health and social care transfer specifically led to a revision of the policy makers' programme theory of training. Empirical research in the form of a factorial survey and narrative analysis of qualitative interviews was then undertaken, to further revise the programme theory to be specific to safeguarding adults training.

Findings emphasise the importance of considering the effect of the training culture and transfer climate on safeguarding adults training effectiveness. Factors such as opportunity to use learning and supervisor support are important to transfer and the conflict between adult learning principles and mandatory training was explored. Safeguarding adults-specific supports were also highlighted, emphasising the importance of supporting practice using mechanisms other than training.

Recommendations are provided regarding how the safeguarding related transfer climate can be improved. Limitations of the study include a high likelihood of sampling bias. The limitations of individual methods and problem of generalising findings obtained from a case study of Cornwall were reduced using the realist synthesis approach.





## Table of contents

Abstract .....	1
Table of contents .....	3
Acknowledgments .....	12
Author's declaration .....	14
Chapter 1 Introduction .....	16
Chapter 2 Safeguarding adults .....	20
2.1 Introduction .....	20
2.2 Nature and scale of the problem .....	21
2.3 Causes of abuse: the conceptualisation of vulnerable people .....	23
2.4 Causes of abuse: discrimination .....	26
2.5 Causes of abuse: structural issues .....	27
2.6 English safeguarding adults policy background .....	30
2.7 Policy and legal definitions: the language of safeguarding .....	35
2.8 Thresholds in safeguarding adults .....	39
2.9 Who is supposed to "do" safeguarding adults? .....	41
2.10 Safeguarding adults and other agendas .....	43
2.11 Safeguarding adults training .....	46
2.12 The Cornish context .....	51
2.13 The focus of this study .....	53
Chapter 3 Safeguarding adults training: policy and evaluation .....	54
3.1 The case for evaluating safeguarding adults training .....	54
3.2 Training evaluation should include the transfer system .....	55
3.3 Safeguarding adults training research .....	58
3.4 Factorial surveys and safeguarding research .....	60
3.5 Factors known to promote successful safeguarding .....	63
3.6 A local perspective .....	69
Chapter 4 Identifying the safeguarding adults training programme theory .....	74
4.1 Programme theories from policy .....	74
4.2 Summary .....	83
Chapter 5 Aims, objectives and research questions .....	86
Chapter 6 Methods .....	90
6.1 Design .....	90
6.2 Systematic literature review with realist synthesis .....	95

6.3	Factorial survey .....	109
6.4	Qualitative analysis of factors impacting on the effectiveness of training....	130
6.5	Synthesising the findings from all 3 methods. ....	140
6.6	Ethics .....	141
Chapter 7	Training transfer research: a systematic literature review with realist synthesis.	143
7.1	Introduction.....	143
7.2	Preface to the literature review .....	143
7.3	Paper characteristics .....	143
7.4	Measures of transfer.....	146
7.5	Learner characteristics .....	149
7.6	Intervention design and delivery .....	165
7.7	Work environment factors .....	177
7.8	Conclusions.....	191
Chapter 8	Search 2: health and social care transfer literature .....	197
8.1	Using the implementation chain to structure the evidence .....	197
8.2	Realist synthesis .....	222
Chapter 9	Results: Factorial survey .....	227
9.1	Introduction.....	227
9.2	Data distribution. ....	227
9.3	Data analysis.....	231
9.4	Results.....	234
9.5	The model reviewed.....	250
9.6	Categorical data .....	253
Chapter 10	Results: Interviews with Provider Manager and Human Rights delegates and Trainers.....	259
10.1	Introduction.....	259
10.2	Impacts of the workshop.....	261
10.3	Provider Manager only impacts: .....	273
10.4	Human Rights workshop only impacts.....	273
10.5	Comparing the impacts of the Provider Manager and Human Rights workshops .....	274
10.6	National policy, and the identification of a skill, knowledge or attitude gap necessitates training .....	275
10.7	Training programmes are devised, and trainers deliver programmes .....	278

10.8	Delegates transfer learning to practice .....	286
10.9	Barriers to safeguarding .....	294
10.10	Safeguarding supports .....	300
10.11	Conclusions .....	304
Chapter 11	Synthesis of empirical findings.....	307
11.1	Causal propositions contained in the second iteration of the programme theory 307	
Chapter 12	Discussion.....	323
12.1	Answers to the research questions .....	323
12.2	Contribution to knowledge .....	329
12.3	Implications for policy, practice and training .....	329
12.4	Critique of the research methods .....	333
12.5	Future research .....	343
12.6	Conclusions.....	346
References.....		348
Appendix A	Abbreviations.....	382
Appendix B	Data comparing Cornish and English social care workforce data. ....	384
Appendix C	Rationale for classifying safeguarding adults training as a complex social intervention.....	387
Appendix D	Search strategy- systematic literature review. ....	389
Appendix E	Systematic literature review screening sheet.....	390
Appendix F	List of journals that Zetoc alerts were received for .....	391
Appendix G	Systematic literature review: Data extraction form fields .....	393
Appendix H	Search 2, realist synthesis: Data extraction form fields .....	395
Appendix I	Studies using the factorial survey method.....	397
Appendix J	Example of vignettes with low and high difficulty ratings.....	404
Appendix K	Factorial survey participant demographic data .....	405
K.1.	Organisation .....	405
K.2.	Job type .....	405
K.3.	Age.....	406
K.4.	Worked in the sector / Worked in current workplace .....	407
K.5.	Training attended .....	408
K.6.	Qualification attainment .....	408
K.7.	Safeguarding experience .....	409
Appendix L	Interview script: Provider Manager/ Team Leader workshop .....	410

Appendix M	Interview script: Human Rights workshop .....	412
Appendix N	Interview script: Training professional.....	414
Appendix O	Interview study participant demographics .....	416
	O.1. Organisation .....	416
	O.2. Job role .....	416
	O.3. Gender .....	417
	O.4. Length of time working in the sector .....	418
	O.5. Length of time since the training was attended .....	418
	O.6. Past involvement in safeguarding adults .....	419
Appendix P	Ethics documentation .....	420
	P.1. Ethical Approval: University of Plymouth .....	420
	P.2. Ethical approval: NHS .....	422
	P.3. Ethical Approvals: Letter of access.....	430
	P.4. Ethical Approval: Cornwall Council .....	432
	P.5. Consent form: vignettes .....	433
	P.6. Consent form: Provider Manager interview .....	434
	P.7. Consent form: Human Rights interviews .....	435
	P.8. Consent form: Trainer .....	436
	P.9. Information sheet: Vignette study .....	437
	P.10. Information sheet: Provider Manager interview .....	439
	P.11. Information sheet: Human Rights interview .....	441
	P.12. Information sheet: Trainer interview .....	443
Appendix Q	Preparation for the Human Rights workshop .....	445
Appendix R	Preparation: Provider Manager workshop .....	450
Appendix S	Correlation matrix of demographic variables.....	452
Appendix T	Table showing number of times each factor was presented throughout the whole vignette study .....	454
Appendix U	Factorial survey regression models pre removing outliers.....	456
Appendix V	Factorial survey categorical data chi-square contingency tables, and odds ratio calculations.....	460
Appendix W	What does safeguarding adults training look like in Cornwall?.....	462
Appendix X	Publications .....	465
	X.1. Publication: Bridging the gap between learning and practice: from where we were to where we are now (2010) .....	466

X.2. Publication: Training, knowledge and confidence in safeguarding adults:  
results from a postal survey of the adult social care sector in a single county (2011)  
489

## List of figures

Figure 1: Predicted impact of each factor on alerting, by training attendance. ....	73
Figure 2: Safeguarding adults training implementation chain .....	75
Figure 3: Relating the implementation chain to the CMO components: Initial model of policy makers' programme theory of safeguarding adults training. ....	85
Figure 4: PRISMA flow chart of selection of the general transfer literature .....	102
Figure 5: PRISMA flow chart of selection of the social care transfer literature .....	104
Figure 6: Diagram showing the effect of a mechanism in a particular context (adapted from Pawson and Tilley, 1997).....	139
Figure 7: 'Ripples' model of adult learning: adapted from Race (2010).....	193
Figure 8: Diagram illustrating some of the relationships between training transfer antecedents, identified in the systematic literature review .....	195
Figure 9: Model of the relationship between training, knowledge, confidence and action. From Pike et al (2011: 269) .....	219
Figure 10: Second iteration of the programme theory, following the realist synthesis. Solid lines represent causal relationships.....	224
Figure 11: Model of the impact of training, to be tested using the factorial survey method.....	225
Figure 12: Graph of ratings of recognition of abuse, from 1 (Definitely not abuse) to 9 (Probably is abuse).....	228
Figure 13: Graph of ratings of reporting of abuse, from 1 (Definitely wouldn't make an alert) to 9 (Definitely would make an alert) .....	228

Figure 14: Graph of ratings of confidence, from 1 (Not at all confident) to 7 (Extremely confident) .....	229
Figure 15: Graph of adjusted ratings of recognition of abuse. Scale extended. ....	230
Figure 16: Graph of adjusted ratings of reporting of abuse. Scale extended.....	230
Figure 17: Model of factors to test in the factorial survey .....	234
Figure 18: Scatterplot of standardised residuals against standardised predicted values: Confidence.....	240
Figure 19: Normality plot: Confidence .....	240
Figure 20: Scatterplot of standardised residuals against standardised predicted values: Recognition.....	244
Figure 21: Normality plot: Recognition .....	244
Figure 22: Scatterplot of standardised residuals against standardised predicted values: Reporting.....	248
Figure 23: Normality plot: Reporting .....	248
Figure 24: Revised model of impact on training and other factors on confidence, recognition and reporting of abuse. ....	251
Figure 25: Final iteration of the programme theory of safeguarding adults training. .	322



## List of tables

Table 1: Factors identified as barriers to alerting.....	71
Table 2: Table of context mechanism and outcomes extracted from English policy.....	84
Table 3: Methods used to answer the research questions .....	91
Table 4: Number of papers found from the general literature search.....	101
Table 5: Number of papers found from the social care literature search .....	104
Table 6: Number of each research design included in the systematic literature review .....	144
Table 7: Job type of participants from papers included in the systematic literature review.....	145
Table 8: Summary of learner characteristics .....	163
Table 9: Summary of intervention design.....	175
Table 10: Summary of work environment factors .....	190
Table 11: Skewness and kurtosis statistics for dependent variables. ....	231
Table 12: Confidence regression results: demographic factors only .....	236
Table 13: Confidence regression results: demographic and vignette factors .....	239
Table 14: Recognition regression results.....	243
Table 15: Reporting regression results .....	247
Table 16: Amendments to causal propositions following factorial survey .....	253
Table 17: Number and percentage of times each categorical option was selected. ...	253

Table 18: Correlation matrix showing recognition and reporting scores versus actions chosen .....	255
Table 19: Pairs of factors tested using Chi Square.....	257
Table 20: Table of impacts of both training programmes. (Antecedents of impacts in brackets; numbers of participants who identified each impact in square brackets) ...	262

## Acknowledgments

Thanks to my Director of Studies, Professor Rod Sheaff and Second Supervisor, Dr Tony Gilbert for providing invaluable advice, support and guidance, and my Third Supervisor Deirdre Ford for encouragement and discussion about all things social work. Thanks also to Galina Borisyuk and Alison Green for providing statistical advice relating to the factorial survey analysis.

Thanks to Roger Indge for coming up with the idea of investigating this issue (among numerous others), and to Corinne Leverton and everyone else at the Learning Training and Development Unit for making me want to carry on with it.

Thanks to friends and family- you know who you are- for reading drafts, providing dinners, listening to rants, accompanying walks and making a failure to learn Latex something to laugh rather than cry about - especially Kate and David.

Thanks to the health and social care staff who participated in the research, and the others who have shown an interest.

Thanks to Anne and David Blight and Starfish people for making presentations easier.

Finally thank you to the University of Plymouth for providing the Graduate School Scholarship, without which this piece of work would not have been possible.



## Author's declaration

At no time during the registration for the degree of Doctor of Philosophy has the author been registered for any other University award without prior agreement of the Graduate Committee.

This study was financed with the aid of a studentship from Plymouth University Graduate School. Whilst the original access to the topic of safeguarding adults training transfer was established through a Knowledge Transfer Partnership project, the research questions and structure of the PhD were designed and conducted by the author with support of her supervisors.

Plymouth University research training courses including Endnote, NVivo, Transfer Process from MPhil to PhD, SPSS, Preparing Effective Poster Presentations, Latex, Introduction to Mysites, Effective Reading, and The Transfer Process were attended, along with a number of lectures from the MSc Research Methods, Social Research Design module. Relevant conferences and meetings were attended, and 2 papers were prepared and published.

### Journal publications:

PIKE, L., GILBERT, T., LEVERTON, C., INDGE, R. & FORD, D. 2011. Training, knowledge and confidence in safeguarding adults: results from a postal survey of the health and social care sector in a single county. *The Journal of Adult Protection*, 13, 259-274.

PIKE, L., INDGE, R., LEVERTON, C., FORD, D. & GILBERT, T. 2010. Bridging the gap between learning and practice: from where we were to where we are now. *The Journal of Adult Protection*, 12, 28-38.

### Presentations and Conferences Attended:

Not just ticking the box: Working towards effective safeguarding adults training. Buckfast Abbey, 23<sup>rd</sup> April 2010 (speaker: "Working towards learning transfer in Cornwall" with Corinne Leverton)

Achieving workforce excellence: Putting learning into practice in social care (Skills for Care Southwest). Sandy Park, Exeter, 1<sup>st</sup> December 2010 (speaker: "Learning transfer in Cornwall: Challenge, change and culture" with Corinne Leverton).

The Postgraduate Society Short Conference Series, University of Plymouth, 17<sup>th</sup> March 2011 (speaker: "An investigation into Safeguarding Adults training transfer in the health and social care sector in Cornwall")

Methods 2011, University of Plymouth, 19-20<sup>th</sup> May 2011 (delegate)

Safeguarding Children and Adults Congress, Birmingham Botanical Gardens, 23-25<sup>th</sup> May, 2011 (speaker: "Improving the effectiveness of safeguarding training")

Doctoral Research Presentation Day, Plymouth University (Faculty of Health), 14<sup>th</sup> June 2011 (speaker: "Necessary but not sufficient: Evaluating safeguarding adults training in Cornwall")

British Society of Gerontology 40<sup>th</sup> Annual Conference, Plymouth University, 5-7<sup>th</sup> July 2011 (delegate)

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**Word count of main body of thesis:**

79,962

Signed

Date

## **Chapter 1 Introduction**

This thesis developed from a Knowledge Transfer Partnership project which was initiated by Roger Indge at Cornwall Council's Learning Training and Development Unit (LTDU) of Adult Care and Support. Roger and his team had reflected on the events surrounding the murder of Steven Hoskin, a man who accessed services due to his learning disability, in 2006. Steven had been in contact with numerous statutory and non-statutory services before he was killed by 'friends' of his. Those services had not recognised the risk he faced by associating with the people he did, and consequently had not intervened. The safeguarding adults process was not initiated for Steven (Flynn, 2007).

Following the Serious Case Review, Roger and his team at the LTDU reflected on the case. They realised that training had not been flagged up as lacking in the case review, which implied that staff had attended safeguarding adults training, but had been unable to put it into practice. They decided to undertake a Knowledge Transfer Partnership project, which aimed to review the evidence base to optimise the design and delivery of training and development for social/care workers involved with the safeguarding of vulnerable adults. The project applied findings from the academic literature on training transfer to the problem of safeguarding adults training. The idea of a three stage approach to training was introduced, and an important realisation was reached; that no matter how good a training programme is, if individuals are not motivated learn and transfer, and the workplace is not supportive of the use of new learning at work, those programmes will not be effective. A number of approaches were introduced to try and address the whole three stages (preparation, training, and

implementation) of the training process, some with more success than others. The project ended in June 2010 having contributed to the design and development of numerous safeguarding adults programmes- see Pike et al (2010).

This work picks up where the Knowledge Transfer Partnership left off, and aimed to identify, develop and refine a programme theory, or mechanism of action, of safeguarding adults training transfer. The resulting thesis encompasses the topics of training transfer and safeguarding adults. Chapter 2 gives an introduction to the English safeguarding adults context, and concludes by outlining the safeguarding adults training recommendations which are made in policy. Chapter 3 outlines the importance of and rationale behind evaluating safeguarding adults training, examines the existing safeguarding adults training research, and considers methods that could be used to expand that literature. Chapter 4 attempts to extract the policy makers' safeguarding adults training programme theory from UK policy, resulting in a model to be tested using secondary, and then empirical data. Chapter 5 outlines the aims and objectives of the research.

The mixed methods approach used in this study is discussed in Chapter 6. Both quantitative (the factorial survey) and qualitative (narrative analysis of semi structured interviews) methods are included, along with a systematic literature review using a realist synthesis approach. The systematic literature review in Chapter 7 discusses the transfer literature generally, while Chapter 8 narrows the evidence to health and social care training evaluation. The policy makers' programme theory is revised in light of the findings from the two reviews.

Empirical findings from research carried out in Cornwall follow. Findings from the factorial survey in Chapter 9 address the question of what impact safeguarding adults



training has on the thresholds to recognising and reporting abuse, using a quantitative measure. A narrative account of the safeguarding adults training programmes delivered in Cornwall, including barriers to and facilitators of transfer is given Chapter 10. Findings from the factorial survey and interviews are synthesised in Chapter 11. The resulting model, which amends the second version of the programme theory in light of the empirical data, articulates a normative model of safeguarding adults training transfer.

The discussion in Chapter 12 outlines the main findings of the research, and the implications for policy, training and practice. The methods of the study are critiqued, and implications for future research are outlined.



## **Chapter 2 Safeguarding adults.**

### **2.1 Introduction**

Safeguarding Adults is increasingly acknowledged as being a critical issue for society (Mantell & Scragg, 2008) and training is highlighted as one of the primary methods of ensuring it is carried out effectively (Department of Health and the Home Office, 2000). Despite having occurred 50 years apart, recent abuse scandals (e.g. Care Quality Commission, 2011a) and scandals from the 1960s, 70s and 80s (Martin, 1984) appear to have similar causes, implying that lessons from inquiries are not consistently being learned or applied to practice. 94,500 referrals about vulnerable adults were made to adult safeguarding in 2010-11 (The NHS Information Centre Social Care Statistics, 2011a), while studies on UK elder abuse alone have conservatively estimated a prevalence rate of 2.6% (227,000 people), implying that abuse as a whole is still massively underreported.

This chapter begins by outlining the nature and scale of the problem and discussing the causes of abuse. It then describes safeguarding adults policy and the other policies and legislation that must be synthesised with it in practice. Grey areas in safeguarding, such as agreeing thresholds to action and balancing the right of the individual to autonomy against the state's responsibility to protect against harm are discussed in relation to the Mental Capacity Act 2005. The practical implications of policy which assumes a shared human rights value system in social care are also discussed.

The findings of Serious Case Reviews often cite staff training, or lack thereof, as one factor which contributed to the occurrence of abuse (Aylett, 2008). The chapter ends by exploring how multiagency Safeguarding Adults training is mandated in the sector. Evaluation of safeguarding adults training in the UK is generally not carried out in any

depth, meaning the effect of providing training on the prevention of abuse is currently unknown.

## **2.2 Nature and scale of the problem**

Abuse is a hidden and often ignored problem (Department of Health, 2010) and in the UK is defined as “a violation of an individual’s human and civil rights by any other person or persons” (Department of Health and the Home Office, 2000, :9). Abuse may be physical, psychological, sexual, financial, or discriminatory, and neglect is also categorised as abuse. There are currently no reliable data available concerning the prevalence of adult abuse generally in the UK but estimates imply it is a significant problem. A study on elder abuse in the UK (O’Keeffe et al., 2007) found the prevalence rate to be 2.6% of people aged 66 and over in the UK (227,000 people) when mistreatment involved a family member, close friend or care worker; this estimate excluded institutional abuse. When the prevalence of mistreatment was broadened to include neighbours and acquaintances, it rose to 4%, equivalent to 342,400 people. The authors recognised that the figures were likely to be an underestimate, but appeared to be broadly in line with previous work (ibid).

A European, multicultural study into abuse and violence against older women reported mean prevalence rates (defined as violence or abuse experienced in the participants’ own home in the past 12 months) of 28.1%. Emotional abuse was reported most frequently, followed by financial abuse. Physical and sexual abuse were least prevalent (or least reported) in all countries, which did not include the UK (Luoma et al, 2011). A systematic literature review found a prevalence range of elder abuse from 3.2 to 27.5% in the general population. The authors provided a comprehensive break down of the measures used, along with other variables that could affect prevalence ratings.

They concluded that over 6% of the older general population, a quarter of vulnerable adults and a third of family carers have been involved in significant abuse, much of which was unknown to the authorities (Cooper, Selwood & Livingston, 2008). The disparity in prevalence rates implies that definition and measurement of abuse have some way to go before valid estimates are obtained, and Cooper, Selwood et al have called for consensus on validity of measures of abuse. Whereas in public health research a clear distinction is made between prevalence (the total number of cases in a population) and incidence (the rate of new cases in a set time period), research on adult abuse “prevalence” appears to be less clear in terms of definitions. Clarity is needed over whether prevalence or incidence of abuse is being measured.

Incidence of other types of adult abuse is also difficult to quantify. Government statistics concerning adult abuse in England come with a number of warnings about their use. Notes accompanying the data, obtained directly from The NHS Information Centre, state that the evidence suggests there was “inconsistent interpretation of the terms Alerts, Referrals, and Completed Referrals between councils” resulting in inconsistencies in reporting data (The Health and Social Care Information centre, 2011). The data quality issues relating to interpretation of the guidance were addressed in a subsequent data collection which included information from 151 of 152 Councils with Adult Social Services Responsibilities (CASSRs) in England (The NHS Information Centre Social Care Statistics, 2011a), which found that 94,500 referrals were made about vulnerable adults to adult safeguarding in 2010-11. Physical abuse was the most common type (36%), followed by neglect (28%) and financial abuse (24%). 19% of referrals related to psychological or emotional abuse, and the remaining 12% comprised sexual, institutional and discriminatory abuse. Comparing these figures

to the literature estimating the prevalence of abuse indicates that the problem is either being underreported or overestimated.

In summary, although exact measures are elusive, it appears that adult abuse is a significant issue in today's society. Numerous safeguarding adults related issues have received media attention in recent years, and the resulting inquiries discuss the numerous structural and cultural issues instrumental in the abuse of vulnerable adults. Incidents include a report on the failure by the NHS to respond to the needs of older people with care and compassion (Parliamentary and Health Service Ombudsman, 2011); the failure to uphold older people's human rights when they receive care at home (Equality and Human Rights Commission, 2011a); the routine neglect of patients at an NHS hospital trust (Francis, 2010; Healthcare Commission, 2009); and institutional abuse of people with a learning disability at a private residential home (Care Quality Commission, 2011a). While the CQC's report on the state of adult social care in England 2010-2011 is generally optimistic, it highlights that a fairly high proportion of services (around 20-30%) are not compliant on a number of outcomes related to welfare, safety and rights (Care Quality Commission, 2011b). Furthermore the accuracy of such inspections has been thrown into doubt, as services such as Winterbourne View, which received a good inspection report before abuse was exposed in an undercover documentary, have been exposed as abusive (*Panorama*, 2011).

### **2.3 Causes of abuse: the conceptualisation of vulnerable people**

In order to understand how the problem of adult abuse can be addressed, it is important to understand its causes. One approach is to consider the conceptualisation

of adults who are vulnerable held by perpetrators of abuse, and arguably by society in general. Wolfensberger (1972) outlined how the ways in which “deviance” is conceptualised affects how “deviant” individuals are treated, and how care services are provided to them. Deviance is described as being “significantly different from others” in a way that is negatively valued (pg. 13). Wolfensberger states that perceptions of individuals as subhuman are a powerful cause of mistreatment. The dehumanising of people, whether through negative labelling or physical acts, contributes towards the perception that

“it does not matter whether this organism is destroyed, dislocated, disowned, or otherwise used at the convenience of those perceived to be human”  
(Wolfensburger, 1972, :18).

Wolfensberger’s ideas about conceptualising people still hold merit. Recent research shows that stigmatisation of certain groups is still occurring today: Behuniak argues that the social construction of people with Alzheimer’s as “zombies” has contributed to their stigmatisation, and further, that theirs is a stigma based on “terror and disgust” (Behuniak, 2011, :83).

Other authors have discussed a ‘neutralisation of moral concerns’ that arises when a person is not judged to be equal to others (Wardhaugh & Wilding, 1993), which goes some way to explaining how abusive treatment of vulnerable adults, or indeed any minority group, can occur.

Other conceptualisations include the “deviant” individual as a “menace”, an object of pity, an eternal child, or a “diseased organism”; a medical model is adopted here, which prescribes diagnosis, treatment and therapy for a disease. Again, long stay hospitals for people with learning disabilities are examples of this, although other

“conditions” such as homosexuality and mental disorder have historically been conceptualised in this way. It can be argued that people with dementia are still often conceptualised as “diseased” today; Bryden (2005) implores against calling people “dementing”, pointing out “If I had cancer, you would not refer to me as ‘cancerous’ would you?” (pg. 97).

In her book on disability hate crime, Quarmby outlines the history of perceptions and treatment of people with disabilities, concluding

“Sinner, slave, scapegoat, stigma and spectacle- a human without humanity, who should be banished from sight and segregated permanently- these images of and prejudices towards disabled people are rooted deep in our culture” (Quarmby, 2011, :26).

Quarmby argues that the negative perception of people with disabilities contributes towards tolerance of abuse and disability hate crime, and society’s reaction to it; she points out that as recently as 2007, disability hate crime, unlike race and religious hate crime, was not recorded by the UK police, resulting in much shorter sentences (when people were sentenced) for perpetrators. Numbers of recorded cases have risen in recent years, but it is likely that the problem is still massively underreported.

Many manifestations of the conceptualisations of “deviant” people outlined by Wolfensberger are encompassed within Kitwood’s concept of Malignant Social Psychology. This undercurrent of care results in dehumanising people by ignoring, invalidating, infantilising, labelling, intimidating, disempowering, mocking and objectifying (Brooker, 2007). Brooker outlines that episodes of Malignant Social Psychology often represent learned behaviour rather than ill intent, and so the culture of care that conceptualises people as “deviant” in whatever way continues, even if the



language of deviance has changed. The high estimates of elder abuse and other ill treatment of vulnerable people may be explained by this underlying, implicit yet largely unaddressed negative perception of people with disabilities or impairments. The question is how to address such attitudes.

## **2.4 Causes of abuse: discrimination**

Building on the conceptualisation of some people as 'less than', other authors have highlighted the importance of viewing abuse through the lens of discrimination, which can be seen as the root of all abuse (Brown, 2000). Elder abuse can be interpreted as a form of ageism, which affects society's perception of the human rights and citizenship of older people (Phelan, 2008) and should be challenged to prevent abuse from occurring (Ward, 2000). Phelan argues that in Western societies where the emphasis is on human economic worth, people who cannot contribute economically experience apathy towards the abuse of their human rights. It is not difficult to apply this premise to other groups who are susceptible to mistreatment who are united in that they lack value and worth in the eyes of society (Wardhaugh & Wilding, 1993).

The originator of the term ageism, Robert Butler, listed stereotypes of older people as "rigid... old fashioned... boring, stingy, cranky, demanding, avaricious, bossy, ugly, dirty and useless" (Butler, 2008, :40). Research corroborates this negative perception of older people; Cuddy et al (2005) found that the stereotype of older people as warm but incompetent was consistent across cultures, and lead a dominant emotional reaction to the group of pity.

Other groups fare equally badly; a survey of over 1000 UK adults found the "typical" person with a learning disability was perceived to have characteristics including "poor

social skills, lack of confidence, shouting, being aggressive or slurred speech” (Turning Point, 2010). A report by the Equality and Human Rights Commission found that disabled people, in particular people with learning disabilities or a mental health issue, were at higher risk of, and suffer more from victimisation (Hoong Sin et al., 2009). Furthermore, a survey of people with mental ill health found that 71% of respondents had been victimised in the community at least once in the past 2 years and felt this was related to their mental health history. Many felt unable, or were discouraged to report even serious crimes, because they felt their concerns would not be taken seriously or acted on (Mind, 2007). Mind’s survey is supported by academic research which has shown that people with psychosis are at high risk of violent and non-violent victimisation in the community (Fitzgerald et al., 2005; Walsh et al., 2003).

This highlights a major challenge in preventing abuse; how can organisations- and society- ensure that all staff possess a human rights value base and recognise that discrimination can be a root cause of abuse?

Developments in policy such as Putting People First (HM Government, 2007), prompted by strong user led movements, have brought person centred support (Kitwood, 1997) into the mainstream. This may reduce levels of discrimination, but there is much progress to be made before “person centredness” is viewed as more than just a buzzword. The implications of personalisation in terms of safeguarding adults are discussed later on, in section 2.6.3.

## **2.5 Causes of abuse: structural issues**

The ‘bad apple’ model of abuse, where abuse is seen to be perpetrated by malicious individuals, has historically been popular in the conceptualisation of abuse (White et

al., 2003). Other authors have categorised staff who abuse as 'sadistic' (i.e. bad apples) or 'reactive' (when staff lose 'immunity' to manage a stressful situation, or do not have the resources or training to cope with the challenges of the job) (Colin-Shaw, 1999). However, much evidence points to the influence of structural or organisational factors in the development of abusive cultures, or cultures that can lead to 'reactive' abuse. An overarching theme is what Martin (1984) termed the "corruption of care" - where

"the primary aims of care... have become subordinate to what are essentially secondary aims such as the creation and preservation of order, quiet, and cleanliness" (p 87)

Martin, who analysed the practices of long stay hospitals in the last century, described the factors that contributed to this corruption including isolation of staff (geographical, professional, social and intellectual); lack of support of people using services, in terms of visits from family, friends or advocates; failures of whistleblowing, leadership, administration and management and resource shortages. The move from institutional to community care aimed to resolve some of these issues but by the 1990s, it became apparent that the transition had been badly planned, and the quality of care people were receiving in some cases amounted, again, to abuse (Nolan, 1993). It became clear that the institution itself had not been the cause of abusive practice, as similar problems were occurring in other settings. Nolan points out that in the 19<sup>th</sup> century, institutionalisation for the insane was hailed as a revolution in care but in reality, many of the attitudes from the previous system of workhouses, prisons and private institutions were absorbed into the new system. There is no reason why the change from institutions to community care would be any different, especially if the same

problems of undervaluing staff, understaffing and working in challenging conditions remain, despite providing services for a lesser number of people.

Martin's themes have recurred and been developed in subsequent literature to include imbalance of power and lack of accountability (Wardhaugh and Wilding, 1993), and to create a check list of early indicators of abuse in residential settings (Marsland et al., 2007). The findings are largely, and depressingly echoed in papers such as Aylett (2008) who identified advocacy, complaints, regulation and monitoring, clinical governance, supervision, policy and procedure, person centred care, management skill and leadership, whistle-blowing, practice standards and skill mix, and practice and policy on restraint as the major themes of more recent serious case reviews; the author's comment that the findings "demonstrate that there are no new messages to be communicated but powerful lessons to be learned" (pg. 9) is all the more pertinent when it is noted that those messages are at least 50 years old.

Another reminder came recently, in the Panorama programme on the subject of Winterbourne View in Bristol (*Panorama*, 2011). Many of the principles outlined by Wolfensberger and Martin can easily be applied to Winterbourne View; massive failures of leadership, conceptualising residents as subhuman or diseased, poorly trained staff more intent on keeping order than providing any 'assessment or treatment', and isolation of both staff and residents. Whistleblowers were ignored by supervisors, managers, and the Care Quality Commission until the failings were highlighted in the media. These contributory factors have been highlighted over and over again in the literature, yet the lessons are not being learned. Furthermore, although training is often highlighted as a failing, it seems apparent that a system-wide

approach (see section 3.2) is needed to effectively address safeguarding issues- which raises the question of how much training can achieve on its own.

## **2.6 English safeguarding adults policy background**

The publication of a letter in *The Times* in 1965 is arguably one of the notable events in the history of recognising and addressing adult abuse in England, because it led to the publication of *Sans Everything* (Robb, 1967). The book outlines poor treatment of older people in ‘mental homes’, focussing on the practice of ‘stripping’, where new residents had their personal possessions including glasses, hearing aids, and dentures taken away. Such abuse was implied to be the norm in the popular press in the late 60s, contributing to governments’ decisions to reduce hospital based, and increase community care provision (Means, Richards & Smith, 2008). However no formal policy on adult abuse was created until 1991.

### **2.6.1 Adults at Risk**

In 1991 the “Adults at Risk” guidance was released partly as a result of the NHS and Community Care Act 1990. It was seen as timely (ADSS, 1991), and provides much of the basis of today’s safeguarding adults policy. It outlined potential risks to people who use services, principles of independence, choice and control, and a process for referring and managing risk along with roles and responsibilities. It was stressed that the guidelines should not be followed “slavishly” (section 5.3), but used in conjunction with professional judgement and common sense. Principles of planning, communication, multi-agency working, and supervision were delineated.

As mentioned above, serious case reviews into the abuse of vulnerable adults are still concluding with the same recommendations highlighted in *Adults at Risk* (Aylett, 2008). There is evidence (see above) to suggest that the work of preventing the abuse of adults at risk, now termed safeguarding adults, is not being carried out in a consistent, effective way across the UK. Although the evidence is patchy, it indicates a substantial problem worth researching.

### 2.6.2 No Secrets

The 1991 ADSS guidance was updated in 2000 by the Department of Health's publication of *No Secrets* which applies in England. The other nations of the UK have different policies; *In Safe Hands* (Healthcare Inspectorate Wales, 2010) in Wales, while Scotland is the only UK nation that has legislation relating to safeguarding adults, in the form of the Adult Support and Protection (Scotland) Act, 2007. Northern Ireland currently has no guidance or legislation, but in 2010 formed a Safeguarding Adults Partnership with the aim of developing policy (Department of Health Social Services and Public Safety, 2010).

*No Secrets* provided further definitions of adults at risk- now termed "vulnerable adults"- as well as the types of abuse they may be subject to (Department of Health and the Home Office, 2000). The policy maintained the status of guidance and was issued under Section 7 of the Local Authority Social Services Act 1970 to aid development of local policy; it does not have the "full force of statute" (ibid: 7) but should be complied with unless there are exceptional local circumstances. This is the policy that still applies in 2012. "Guidance" as defined by NICE (National Institute of Clinical Excellence) is "recommendations produced by NICE for the NHS and other organisations" (NICE, 2011), and *No Secrets* appears to have a similar position, in that

it offers recommendations for practice rather than structures and processes which are enforceable by law. It aimed to guide the production of local multiagency codes of practice, after agreement that this approach would be better than a national strategy; it is implied that local procedures are better due to the diversity of circumstances in which harm and exploitation occur (Department of Health and the Home Office, 2000).

Safeguarding adults now refers to

“all work which enables an adult *‘who is or who may be in need of community care services’* to retain independence, well-being and choice and to access their human right to live a life that is free from abuse and neglect” (ADSS, 2005, :5) (original emphasis)

Unlike child protection, where The Children Act 1989, supplemented by The Children Act 2004 sets out a holistic approach to safeguarding in the wider context of children’s wellbeing, safeguarding adults in England has no equivalent legislation (Department of Health, 2009a); instead practitioners must reference a wide range of law (The Law Commission, 2011). This means that abuse may be unethical but not illegal; and even if it does reach the threshold for prosecution as a crime, providing water-tight evidence is a challenge. It was made clear in the feedback from the 2008 consultation into the review of *No Secrets* that adults do not wish to be treated as children, and it is argued that safeguarding adults is more complex than safeguarding children because of the issues of consent and capacity (Department of Health, 2009a). In response to the lack of legal clarity, some organisations including Action on Elder Abuse have taken a lead from the USA in considering using civil law to prosecute perpetrators of abuse (Fitzgerald, 2011).

Expressions of support for the introduction of safeguarding adults legislation in England (Department of Health, 2009a) culminated in a response from then UK Minister of State Phil Hope which suggested that legislation would be introduced to give Safeguarding Adults Boards statutory powers (Department of Health, 2009c). However with the change of UK government from Labour to a Conservative/ Liberal Democrat Coalition in 2010, there has been a move towards a smaller state and the “Big Society” (Number10.gov.uk, 2010). This change in policy away from centralised government control and towards individual responsibility indicated that legislation changes may not be forthcoming for some time. However a statement on government policy on adult safeguarding released in 2011 builds on *No Secrets*, by asking local authorities to abide by the principles of Empowerment, Protection, Prevention, Proportionality, Partnership, and Accountability (Department of Health, 2011a). It stated that the government sought to legislate for Safeguarding Adults Boards, which would make them statutory, but gave no time frame for these changes.

### 2.6.3 Personalisation

The move to more personalised services, as outlined in *Putting People First* (HM Government, 2007) does not always sit comfortably with safeguarding adults. *Putting People First* outlined the government’s “commitment to independent living for all adults” (ibid: 1). This has translated into the widespread use of self-directed support, which involves finding out what is important to people with social care needs, and supporting them and their families to plan how to use the resources available to achieve these aims. It entails focussing on outcomes, and maximising choice and control for individuals (I&DeA Association of Directors of Adult Social Services & Local Government Association, 2009), and states that “risk is no longer an excuse to limit



people's freedom" (Department of Health, 2010, :25). However, many commentators have raised concerns that increased choice may also mean increased opportunity for harm, particularly financial abuse, but also grooming of individuals by people with an intention to cause harm (Department of Health, 2009a; Manthorpe et al., 2009b), while statutory services will be left with less control over who services are provided by. The government has suggested that to mitigate the risks of safeguarding and personalisation, local councils should ensure that professionals, individuals, and communities know what part they have to play in safeguarding (Department of Health, 2010). Schwehr (2010) argues that an understanding of mental capacity legislation is the crucial link between safeguarding and personalisation, and goes on to outline the legislation that already exists and has done for some time linking care provision, personalised services, safeguarding and mental capacity with other considerations. She outlines the risks of personal budgets such as improper spending of the money, financial abuse, people employing direct payment workers without training them, or difficult working environments, and argues that the legal framework for care management is the "only available answer at this point" (pg. 47). Both of these solutions to managing the potential conflict between safeguarding and personalisation centre on workforce development and awareness raising. A challenge in this task is the dynamic and changing nature of safeguarding and the agendas that surround it.

Personalisation raises further workforce development issues. Personal assistants are unregulated (meaning CRB checks and training are optional) and growing in number (Skills for Care, 2011a), often working one to one in a close relationship with their employer. While personalisation could be good news for people who use services in terms of being more in control of their support, the safeguarding adults implications,

including where the responsibility lies when an unregulated worker, paid with local authority funds, abuses a person at risk, have not yet been clarified (ibid). Skills for Care argue that the implications of personalisation, including using a more diverse workforce, necessitates a change in culture to concentrate on the outcomes determined by people and communities. This is a massive task, but one that has the potential to reduce the incidence of abuse.

## **2.7 Policy and legal definitions: the language of safeguarding**

The concept of safeguarding has changed over time, from initially aiming to “protect” vulnerable adults to “safeguarding” them from harm, and now to recognition and promotion of their human rights. The change in terminology is significant as it signals a move towards a more personalised concept of safeguarding where the person’s voice and decisions are heard throughout the process.

The Commission for Social Care Inspection (CSCI- now the Care Quality Commission, CQC) adopted the “safeguarding adults” terminology throughout its safeguarding adults guidance and protocol in 2007. It stated the change, “moves away from locating the cause of abuse with the victim” and affords safeguarding adults and children equal status (Commission for Social Care Inspection, 2007, :2).

However some commentators argue that the shift has been “Orwellian” in nature; McLaughlin (2007) asserts that the UK governments’ commitment to prevent abuse, rather than just responding to it, carries an “increased mandate for state intrusion into people’s lives” which contributes to blurring the boundaries between public and private, personal and political (p 1274). This illustrates the controversial nature of the topic.

Safeguarding adults policy applies to “vulnerable adults”. A vulnerable adult is defined as someone who is over 18 years old,

“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” (Department of Health and the Home Office, 2000, :8).

However a consultation into the review of *No Secrets* identified that the term “vulnerable” may be outdated. ADSS (2005) highlighted that the label can appear to locate the cause of abuse with the victim rather than the perpetrator and it has been criticised as “stigmatising, dated, negative and disempowering” (The Law Commission, 2011, :114). The term “adult at risk” (which has been adopted in Scotland) may be preferable because it recognises that specific situations create risk, rather than attributing risk of abuse to an idea of global vulnerability attached to the person.

Abuse is defined as “a violation of an individual’s human and civil rights by any other person or persons” (Department of Health and the Home Office, 2000, :9), and can be a single or repeated act. Anyone can be a perpetrator, and it can happen in any setting. Seven categories of abuse are outlined in *No Secrets*, which are adopted to various degrees by local authorities; these are

- “Physical abuse, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions
- Sexual abuse, including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent 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, isolation or withdrawal from services or supportive networks

- Financial or material abuse, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.
- Neglect and acts of omission, including ignoring medical advice or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating
- Discriminatory abuse, including racist, sexist, that based on a person's disability, and other forms of harassment, slurs or similar treatment"

(Department of Health and the Home Office, 2000, :9)

Furthermore these acts may be perpetrated intentionally, through negligence or ignorance- no data is currently available to ascertain how much adult abuse is intentional (Brown, 2010; Julian, 2009).

Additional categories of abuse are utilised by some local authorities. Self-neglect is included under neglect and acts of omission, but little guidance is given around how, or indeed whether, to manage it. Many local authorities do not include self-neglect under safeguarding, and some specifically exclude it. A recent research report identifies a number of ways of conceptualising self-neglect, complexities around interpreting Mental Capacity legislation in relation to it, and tensions between respect for autonomy and duty of care (Braye, Orr & Preston-Shoot, 2011a). The report should inform future strategy and policy around self-neglect.

Institutional abuse is a separate category of abuse, defined in a number of ways, including

"The "rigorous" implementation of a Care provider's care Regime, Practices, Policies or Procedures that may negatively impact on a person's rights... the mistreatment of people brought about by poor or inadequate care or support or systematic poor practices that affects the whole care setting. It occurs when the individual's wishes and needs are sacrificed for the smooth running of a group, service or organisation."

(Harrow Council, 2011)

“institutional abuse... features poor care standards, lack of positive responses to complex needs, rigid routines, inadequate staffing and an insufficient knowledge base within the service” (Department of Health and the Home Office, 2000, :12)

These definitions strongly relate to Martin (1984)'s idea of 'corruption of care', as discussed earlier. The lack of clear thresholds in these definitions is problematic- what are “poor care standards” or a “lack of positive response to complex needs”? Furthermore many of the problems, such as understaffing, may be related to resources and hence difficult to resolve. This should not be used as a reason not to act, but equally need to be considered (along with the likely impact of training) if realistic solutions to problems of abuse are to be found.

Another definition explains that institutional abuse occurs on a “spectrum” (Department of Health and the Home Office, 2000, :10) but does not indicate where on the spectrum the abuse needs to lie before action should be taken. The spectra over which situations vary are also multidimensional; for example, careless versus deliberate, resource or attitude based, or and consistent or inconsistent. These dimensions may also influence if and when an alert is made. This presents a challenge for workforce development.

The varying responses to self-neglect, and differing definitions of institutional abuse are examples of areas of national inconsistency in safeguarding adults which makes it difficult to, amongst other things, collate national prevalence statistics. It also may contribute to the fact that only 4% of reported abuse was classed as institutional in

2009-2010. Self-neglect was not mentioned (The NHS Information Centre Social Care Statistics, 2011b).

## 2.8 Thresholds in safeguarding adults

The issue of thresholds at which action should be taken is a key one in safeguarding, as many definitions are somewhat vague. *No Secrets* refers to “significant harm”, a term introduced in the Children Act, both in defining a vulnerable adult as a person who cannot protect herself from it, and in defining abuse, which may result in it. The concept of harm is outlined to include;

“not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development.” (Department of Health and the Home Office, 2000, :12)

The term “significant” is not discussed, although *No Secrets* recommends considering vulnerability, nature and extent of abuse, impact on the individual and risk of repeated acts (ibid). The recent Law Commission report explained that the rationale of using ‘significant’ was to denote harm above trivial, but not as high as serious. Consultation highlighted that the term was not helpful and that further clarity over who is an adult at risk would be more beneficial than defining harm thresholds (The Law Commission, 2011).

Thresholds for intervention may also be influenced by individual cases, professional interpretation, personal values, and whether an intervention could be effective (Harbottle, 2007). The use of the factorial surveys, a method used in this study, has

recently gained attention in the literature as a way to investigate threshold judgements (Davies et al., 2011; Killick & Taylor, 2011).

Further vague terms include “wilful neglect” and “ill treatment”. It is unclear whether “wilfulness” is defined by levels of harm, intent or both. The Mental Capacity Act 2005 created a criminal offence of ill treatment or wilful neglect of a person who lacks capacity. Again, the concepts can be viewed on a spectrum from mild to severe and threshold for criminality is unclear. Manthorpe et al (2009a) addressed this issue in an interview study with safeguarding adults professionals, who expressed uncertainties about defining the term “wilful”, especially in the context of understaffed care homes and high levels of neglect. Despite the ambiguity, it appears that to date (May 2010) at least nine convictions have been processed under the law (The Law Pages, 2011b) and 6 of those resulted in a custodial sentence, the longest being for 1 year and 6 months. It is difficult to obtain exact numbers of convictions, however one conviction resulted in a fine of £30,000; the judge said the defendant, a care home owner, was unqualified to do her job and had not kept up to date with legislation to protect vulnerable adults. Another case leading to conviction was described as

“an appalling story of wilful neglect in management, assessment, admission, training, supervision, caring and maintenance of vital records”. (The Law Pages, 2011a).

Again, this picks up on the themes identified by Martin (1984). One author has made the observation that convictions for neglect do not appear to require an intention to harm- as many other crimes do (Series, 2011). Lack of training or updating knowledge was identified in both cases as a failing.

The issue of thresholds has been discussed by Collins (2010) who points out that the “if in doubt, refer” expectation outlined in most safeguarding adults policies does not tally with the amount of abuse which is actually reported. Collins mentions a reluctance to report due an awareness of the resource implications that triggering adult protection procedures will have on social workers, and fears of a “draconian response” (p6) in some services. He advocates a no blame culture to counteract this.

Northway et al (2004) noted a “continuum of severity” (p32) that appeared to exist in perceptions of abuse. Thresholds at which people made alerts were not aligned with policy; although some staff asserted that “abuse is abuse”, others classed some forms of abuse as more severe than others, and requiring a different response. Other literature, explored in more depth in Chapter 3 also supports these findings (Furness, 2006; Parley, 2010; Pike et al., 2011; Taylor, 2003).

One apparent issue here is how to support staff to adhere to policy which states that all abuse is equally as bad; can training aid this bias in reporting?

## **2.9 Who is supposed to “do” safeguarding adults?**

It is worth considering who the state is asking to perform the function of safeguarding, and consequently who will need safeguarding related learning and development. Safeguarding adults is a statutory responsibility, led by Adult Social Care departments of local authorities and supported by the NHS, police and independent providers. Furthermore, there has been a drive to make safeguarding adults ‘everyone’s business’, meaning that other groups- such as community and voluntary groups, faith based organisations and departments other than Adult Social Care in local authorities are expected to know how to recognise and report abuse. This is a massive task.



It appears that safeguarding adults is a fairly well recognised agenda in Adult Social Care departments, while the NHS has struggled to own it (Department of Health, 2009a). Perhaps in response to these observations, safeguarding adults has been made a priority by the Nursing and Midwifery Council in 2011 (Nursing and Midwifery Council, 2010). Statistics collected about reporting trends show that 44% of alerts were from social care staff compared to 21% from health staff (The NHS Information Centre Social Care Statistics, 2011a), although it is unclear what proportions would be expected if all health and social care workers were correctly reporting abuse. Previous data also showed that referrals for different client groups varied by source; for example adults with mental health needs had a higher percentage of referrals from health staff than other client groups (The NHS Information Centre Social Care Statistics, 2011b).

The questions of remuneration, turnover and qualification of the workforce also need consideration in the context of safeguarding and human rights. A Skills for Care report estimates that there were 1.75 million paid jobs in Adult Social Care in England in 2009 (Eborall, 2010). The median gross hourly rate of cashiers was £6.47 in April 2009, almost 50p per hour more than care workers in the private sector, while the turnover rate for care workers was 22.8%. Many domiciliary care workers are not paid the minimum wage due to being paid by the visit rather than the hour, and being under or unpaid for travel time (The Low Pay Commission, 2011). Furthermore, although the data is patchy concerning training and qualifications in the sector, 10-15% of care homes and 20% of domiciliary care agencies had not met the national minimum standards for qualifications at the end of March 2009, and in 2008 7% of care assistants and home carers had no qualifications (Eborall, 2010). This has implications

for the quality of care provided; it is recognised that in order to promote the human rights of people who use services, the human rights of staff must also be respected (e.g. Care Quality Commission, 2010). Among the 1.25 million staff who are providing direct care to people, a combination of very low wages, high turnover rates which imply dissatisfaction with working conditions and challenging work requiring the ability to synthesise a number of complex concepts, policies and procedures does not seem to fulfil this ideal.

## **2.10 Safeguarding adults and other agendas**

### **2.10.1 Human Rights**

Safeguarding adults is concerned with preventing violations of a person's human or civil rights. An awareness of our human and civil rights is therefore important to safeguarding. CSCI noted the Human Rights Act 1998 as being a key driver for adult safeguarding (Commission for Social Care Inspection, 2008b) and the importance of an awareness of human rights was emphasised in their report on the effectiveness of safeguarding adults arrangements, which stated,

“arrangements work best where the whole system is underpinned by shared objectives and a common human rights value system” (Commission for Social Care Inspection, 2008a, :78)

This has been followed up by CQC in their Equality and Human Rights scheme (Care Quality Commission, 2010). The scheme is intended to empower people who use services by using a person centred approach, with a focus on outcomes and the protection of human rights. This approach is supported by some authors who argue that rights are more enforceable than more abstract concepts like quality or need,

making it easier to measure the standard of care provided (Manthorpe & Stanley, 1999).

### 2.10.2 Mental Capacity and Deprivation of Liberty Safeguards

An additional challenge in adult safeguarding stems from the consideration that must be given to people's capacity to decide how they would like abusive situations to be managed. The Mental Capacity Act 2005 states that all adults with capacity have the right to make choices about their lives. Everybody is assumed to have capacity to make a choice, unless it can be proved otherwise. A lack of capacity to make a particular decision is determined by undertaking a capacity test, and every effort should be made to enable people to make their own decisions. This means that even if abuse has been recognised and reported, people with capacity who have been abused have the right to refuse the support of safeguarding services. *No Secrets* recognised the right of adults to make decisions despite being published before the Mental Capacity Act 2005 was implemented, but the Act makes this right law. People are not judged to have global 'capacity' or not, but judged on their capacity to make a specific decision at a specific time; furthermore, risk of harm to others must also be considered where people choose not to progress a safeguarding issue.

The Deprivation of Liberty Safeguards (DOLS) were implemented in 2009 as an extension of the Mental Capacity Act 2005. They apply to people who lack capacity to make decisions about their care, and for whom a deprivation of liberty is considered necessary in their best interests to protect them from harm.

The relationship between capacity and safeguarding is not a simple one. Cambridge (2005) and Mansell (2009) highlight the relative lack of safeguarding adults cases in the field of mental health. It appears that where capacity and consent are lacking,

safeguarding adults action is more difficult to initiate or progress. The question of capacity has also prevented prosecution of alleged abusers in some cases, due to the challenges associated with people who lack capacity acting as a witness (Commission for Social Care Inspection, 2008b). It appears therefore that safeguarding can be hindered when people do not have the capacity to consent to action being taken; but also when they do have capacity and do not wish any action to be taken. Furthermore, anecdotal evidence suggests there is an additional problem emerging, when a person is deemed to have capacity to decide whether safeguarding should be progressed, but is also experiencing coercion from their abuser. The Mental Capacity Act 2005 does not address this issue specifically, although the use of Advocates in safeguarding cases may go some way to identifying coercion by abusers. Although the use of advocates is recommended both to prevent abuse and to improve the safeguarding process (Wallcraft and Sweeney, 2011), it is unclear to what extent advocates are currently used in safeguarding adults cases. The relationship between capacity and self-neglect has also been highlighted as complex (Braye, Orr & Preston-Shoot, 2011a).

The interconnectedness of the Mental Capacity Act 2005, DOLS and safeguarding adults was highlighted in the consultation of the review of *No Secrets*; respondents requested integrated training on the three subjects (Department of Health, 2009a). This reflects recognition of the complexity of applying these concepts in practice. In an interview study, most safeguarding adults professionals cited the effects of the Mental Capacity Act 2005 as fundamental or key to their work, and respondents identified a range of concerns within which safeguarding and mental capacity overlap (Manthorpe *et al.*, 2009a).

Other legislation and policy that bears upon safeguarding adults guidance has been outlined by CSCI (Commission for Social Care Inspection, 2008b; Commission for Social Care Inspection, 2008a), and includes The Domestic Violence, Crime and Victims Act 2004, which introduced the offence of causing or allowing the death of a child or vulnerable adult; Our Health Our Care Our Say (Department of Health, 2006), which outlined a vision for a more personalised health and social care system; the Valuing People white paper (Department of Health, 2001), which outlined principles of rights, independence choice and inclusion for people with learning disabilities; the Safeguarding Vulnerable Groups Act, 2006 (Independent Safeguarding Authority, 2009), which introduced a vetting and barring scheme for staff working with vulnerable people; and the Equality Act (2010) which elaborated and reinforced equality legislation.

## **2.11 Safeguarding adults training**

### **2.11.1 Policy recommendations**

Training is a required component in the implementation of safeguarding adults guidance and a main element of the safeguarding adults strategy (ADSS, 1991; Department of Health and the Home Office, 2000). Other structural and management elements of implementation are also listed, and it is implied that all the components are necessary for the strategy to work effectively.

*No Secrets* states that training should be provided for staff and volunteers on the policy, procedures and practices that are in place locally, as a rolling programme at a number of levels. No staff group should be excluded. However there is very little detail in any policy regarding what such training should contain, or how it should be

delivered. The implication is that training is provided in order to “ensure that procedures are carried out consistently”, but this simplifies an extremely complex issue. As outlined above, safeguarding adults entails understanding of the principles of human rights and the Mental Capacity Act 2005, while taking into consideration the right of an individual to refuse services, the effect an intervention might have on a situation and the challenges of whistleblowing in an organisation. Add to that the complexities of each individual person and their case, and it becomes clear that safeguarding is about much more than following a procedure.

Furthermore the mechanism of action or “programme theory” (Pawson et al., 2004) is ill-defined in policy documents; it is not clear how providing training is meant to impact on the implementation of a safeguarding adults strategy. Many organisations have badged safeguarding adults training attendance as ‘mandatory’, which shifts the emphasis of training from meeting a learning need to compliance. This is illustrated by the tag line of one social care training provider: “Legal compliance at a sensible cost” (Allsorts Training, 2011).

As a result of providing guidance rather than taking a more prescriptive approach, the format and content of safeguarding adults training, as well as local policies and procedures, varies between local authorities. This has the advantage of allowing flexibility to meet the specific needs of a geographical area, but the drawback of a lack of clear guidance regarding best practice in training; there is no mention of how to train staff effectively. Safeguarding adults is an emotive, political and complex issue, and training and its implementation topped the list of recommendations and requirements made by Commission for Social Care Inspection after safeguarding inspections (Commission for Social Care Inspection, 2008a). Despite this, safeguarding

adults policy and guidance has never acknowledged the literature regarding training transfer (the use of knowledge and skills learned in training back at work).

Training is frequently mentioned as being important in the implementation of a policy or initiative, without analysis of how training is meant to effect change (e.g. Care Quality Commission, 2010). Perhaps as a result of this, there is almost no academic literature evaluating the impact of safeguarding adults training. The situation does not appear to be limited to safeguarding adults training; academic attention has historically focussed on social work education, rather than social care training. Preston-Shoot questions the cause of this “neglect” of social care training in academia, hypothesising that training may be seen as “less worthy of interest than education” (Preston-Shoot, 2006, :663). This is concerning when we consider that of a workforce of over 1.6 million, only 110,000 are classed as ‘professional’ (Skills for Care, 2011a); there are significantly more staff who will undertake social care training than receive social work education.

### 2.11.2 Welsh and Scottish policy

Comparing English, Welsh and Scottish guidance on training will give a clearer idea of whether there are significant differences in policy regarding training, and subsequently inform judgements about the generalisability of this research to Wales and Scotland.

In *Safe Hands* (National Assembly for Wales, 2000) is the Welsh guidance, and has a similar approach to training as *No Secrets*; training is cited as a preventative intervention, but there is little further mention of how training should be provided. As in *No Secrets*, there is no mention of training transfer or the mechanism of action by which training is meant to work. There is, however, an assumption that training is

good- “Well-trained staff are worth the money spent” (pg. 69), and that training should be provided to all levels of staff.

Unlike England and Wales, Scotland has introduced legislation in the form of the Adult Support and Protection (Scotland) Act 2007 to, among other things, make provision for the purpose of protecting adults from harm. The Act provides powers to services to intervene where harm (note: not abuse) is suspected, which includes being able to move an adult at risk or an abuser away from the situation. The approach to training is similar to England and Wales, although guidance to Adult Protection Committees (The Scottish Government, 2009) discusses a national training strategy, as well as a local training strategy. A national training programme, “Tell Someone” has been provided (free of charge) to providers; a large scale evaluation of the training was also funded by the Scottish Government (Dementia Services Development Centre, 2010). Multiagency training is advocated as an important part of good joint working. The guidance outlines a range of people who training should target, including people who use services. There is nothing specific in the Act about training, but the Scottish Social Services Council stipulates that 5 of the 15 days of training that staff must complete to maintain their registration must be protection (adult or child) orientated. The government indicated that voluntary take up would be preferable, but they would make it mandatory if required; take up has been over 90% (Macaskill, 2011).

### 2.11.3 Multi/ single agency training

Currently most safeguarding adults training is carried out in multidisciplinary groups comprising statutory, independent and voluntary sector staff. *No Secrets* states that multi-agency management committees should “facilitate joint training”, and ADSS state that it is of “great benefit” if staff participate in multiagency safeguarding adults



training (ADSS, 2005, :19). Other authors have called for access to multiagency training for frontline staff beyond health and social care, such as housing, to support a consistent whole system approach to safeguarding adults (Action on Elder Abuse & Better Government for Older People, 2004). However there is little evidence to support the notion that multiagency training is more effective than single agency training.

Barr et al (1999) outline the distinction between multiprofessional education- where two or more professions learn together, and interprofessional education- when two or more professions learn about and from each other to promote collaborative practice (as is needed in safeguarding adults). A Cochrane review of the effectiveness of interprofessional education (Reeves et al., 2008) found only 6 studies that met inclusion criteria. 4 produced some positive outcomes, and two reported no impact on professional practice or patient care. Reeves and Zwarenstein state that interprofessional education has more potential for enhancing professional practice than multi or uniprofessional education. However we still have limited understanding of the effects of interprofessional education, and how the desired outcomes are achieved (Reeves et al., 2010); also there are some exceptions (e.g. Hallin et al., 2011). Additionally, safeguarding adults training, as well as being more multiprofessional than interprofessional, is delivered to staff with a range of qualifications, from a range of educational backgrounds and with differing levels of openness to learning. There does not appear to be any evidence to suggest that training in safeguarding adults is best delivered in a multiagency format; yet this is the way it is delivered, because of an assumption by policymakers that multiagency training will result in better multiagency working.

## 2.12 The Cornish context

This study took place in a single local authority; Cornwall. Contextual features unique to the county are outlined below.

Two major safeguarding adults failures have occurred in Cornwall in recent years: the murder of Stephen Hoskin in 2006, and the abuse of people with learning disabilities at Budock Hospital in 2005 (Commission for Healthcare Audit and Inspection, 2006; Flynn, 2007). Following on from the serious case review into Hoskin's murder, all recommendations (system wide and agency specific) have been completed. This has had the effect of raising the profile of safeguarding adults in Cornwall, leading to investment in structures around the process and awareness raising (Flynn, 2010) which may not be present in other local authorities. It is unclear whether this has increased organisations' commitment to training. Although many resources have been invested in the safeguarding adults training provided by Adult Care and Support's Learning Training and Development Unit, until now there has been no systematic research undertaken to determine its impact. As is the typical UK picture, currently around 3000 staff and volunteers of a workforce in excess of 25000 are trained each year.

It is not yet possible to compare data regarding the number and nature of alerts across counties (The Health and Social Care Information Centre, 2011). A Freedom of Information request was made to the Independent Safeguarding Authority to find out how many referrals had been made in the UK by county. The request was declined on the grounds of 'Appropriate Limit and Fees', as it would have incurred a cost of over £450 to answer, because their data is not usually categorised by county.

Geographically, Cornwall is an isolated peninsula with only one border (with Devon), which has experienced higher than average population growth resulting from

migration in the last 40 years (Williams, 2003). The estimated population in mid-2010 was 535,300 (Office for National Statistics, 2011). Cornwall has an older population than England generally; the percentage of the Cornish population under age 49 is markedly lower than the English average (Cornwall Council Community Intelligence Team, 2010). Older age has been identified as risk factors for abuse (O’Keeffe *et al.*, 2007), meaning levels of abuse in Cornwall may be higher than elsewhere. Cornwall received “Objective One” funding from the European Regional Development Fund between 2000-2006, because Gross Domestic Product per capita was under 75% of the European National Average. The scheme aims to raise standards of living in deprived areas of Europe. Between 2007 and 2013 it will receive Convergence funding, based on the same principles (Cornwall Council, 2011b). Cornwall’s Health Profile (Department of Health, 2011b) shows that the health of people in Cornwall is generally better than the UK average, and that deprivation in the whole county is lower on average, although there are areas of Cornwall (especially in the West) that have the highest possible deprivation score. A Joint Strategic Needs Assessment identified a higher incidence of safeguarding adults alerts in areas that were more deprived; people who live in the most deprived areas were 1.85 times more likely to be referred to the safeguarding adults process than the Cornwall average. This may be due to underreporting in more affluent areas (Cornwall Council, 2011a).

It is unclear whether these factors affect either the response to abuse in Cornwall, or the effectiveness of training in the social care workforce. A metaanalysis of factors affecting transfer found small correlations between trainee characteristics (including age, education, male gender, and experience) and training transfer (Blume *et al.*, 2010). However the statistics on the social care workforce (see Appendix B ) show no

major differences in the demographics of the workforces of Cornwall and England in these areas. The UK 2011 census would have been useful to make more definitive comparisons, but unfortunately the data will not be published in time.

### **2.13 The focus of this study**

Policy, in the form of *No Secrets* (2000) and *Safeguarding Adults* (2005) implies the programme theory that the perpetration or continuation of abuse is caused, or contributed to at least in part by a lack of staff knowledge. Hence training uses the mechanism of imparting knowledge to resolve this problem, resulting in a change of staff behaviour, which leads to less abuse. A detailed analysis of the policymakers' programme theory is offered at the end of Chapter 4, and the primary and secondary research outlined in later chapters tests this programme theory. The following chapter discusses policy and literature relating to safeguarding adults training evaluation.

## **Chapter 3 Safeguarding adults training: policy and evaluation**

### **3.1 The case for evaluating safeguarding adults training.**

The question of whether Safeguarding Adults training ‘works’ has not gone unnoticed by policymakers: the consultation on the Review of the *No Secrets* guidance (Department of Health, 2008) outlined how, despite the fact that local authorities were using resources to “slowly and often repeatedly” train the care sector in safeguarding adults, “it is however not clear what is being achieved through training”. Furthermore, although data on training is collected annually from local authorities, it can’t be meaningfully aggregated “because there are no nationally set standards for training” (ibid: 22).

Tentative conclusions are being alluded to by some local authorities about the impact that training is having on levels of reporting of abuse, but this is anecdotal evidence. There is also the question of what such a trend would mean; higher rates of reporting could indicate either more abuse, or better recognition and awareness of the procedures (Care and Social Services Inspectorate Wales, 2007).

Despite this lack of knowledge of the effectiveness of safeguarding adults training, it is recommended on a grand scale as a way to improve services. Manthorpe and Martineau (2011) identified training as a recurring recommendation in serious case reviews. Training was cited as a requirement in thirteen of twenty two reviews analysed for the study. Lack of awareness of safeguarding procedures, systems, and timescales were mentioned as reasons to provide training. These recommendations carry an implicit message that training has the potential to raise such awareness, and presumably also enable people to change their behaviour. Without evaluating safeguarding training, there is no way to tell if this is truly the case.

The report on the consultation of the *No Secrets* review (Department of Health, 2009a) showed a recognition by respondents of the importance of knowing whether training is effective and the current lack of attention to this issue. Support was raised for the introduction of an outcomes framework for safeguarding that included higher level indicators, such as linking safeguarding to health, wellbeing and dignity measures, as well as “more immediate” indicators which include timeliness of multiagency response, and “more and better training” (pg. 27). No further details are given on what “better” training would look like, although a desire for the outcome of “more effective training” was also expressed (pg. 28). 97% of respondents stated that they wanted training reviewed with the aim of developing national occupational standards across agencies. Respondents from health all believed that current arrangements for the delivery of safeguarding adults training should be reviewed and increased, and current arrangements were described by many as “cursory” (p.43).

### **3.2 Training evaluation should include the transfer system**

Since the review, staff from Bournemouth University have written a set of safeguarding training competencies which are undergoing a process of endorsement by national organisations such as CQC and ADASS (Galpin, 2010). This has the potential to standardise the provision of training, and aid evaluation by providing clear standards against which training transfer can be measured.

Kirkpatrick (1977) outlined four levels of training evaluation; reactions, learning, behaviour change and attainment of organisational goals. Horwath and Morrison (1999) point out that as level of social care training evaluation increases, it is more difficult to say whether the training, or other factors caused the change. While reactions to training are clearly influenced by the training, attainment of organisational

goals may also be influenced by factors such as quality of supervision, staff turnover, organisational change, and work culture (Horwath & Morrison, 1999); hence, even if the training content and delivery are perfectly suited to the subject, a plethora of other factors will also influence the level of transfer of training into practice. It seems logical that a true picture of the 'effectiveness' of training will not be obtained without ascertaining how supportive the system is of transfer.

Systems theory (von Bertalanffy, 1968) states that events are affected by a whole system of factors, rather than having one sole cause. Systemic analysis focuses on interactions within and across multiple social systems, which can include interpersonal, organisational, social policy and social structure systems (Healy, 2005). It has been used extensively to conceptualise social work, as it takes into account the environment that a person is in and the person's interactions with that environment, as well as the person's characteristics. Clarifying the importance of factors outside training, such as feedback on practice, managerial support and intention to change practice will be a key outcome of this study. Evaluation of training would also help to reassure practitioners that they are "doing the right thing" (in undertaking training) rather than just "doing things right" (i.e. following procedures)" (Munro, 2011, :6). This has been identified as a necessary shift in the child safeguarding system, and is also applicable in adult safeguarding where while procedures and processes are becoming more established with time, the voice of the person has been identified as missing (Department of Health, 2009a).

Systems theory has been used to develop a multi-agency approach to safeguarding children case reviews, which states that,

“The cornerstone of a systems approach is that individuals are not totally free to choose between good and problematic practice. Instead the standard of performance is connected to features of people’s tasks, tools, and operating environment.” (Fish, Munro & Bairstow, 2008)

This exact principle can be transferred to safeguarding adults training: even if we optimistically presume that only a minority of people who abuse set out to inflict harm, (no evidence on intentionality of abuse is currently available (Brown, 2010; Julian, 2009)) best practice regarding the prevention and reporting of abuse is not always followed- even by staff who have attended training. This implies that is it the issue of training transfer that needs attention. The research that exists in the field of training transfer implicitly supports the concept of systems theory outlined above, as it covers investigations into a range of factors that may influence transfer. Furthermore, the assumption that transfer is a function of a system of influences is one widely used by training transfer researchers (Holton & Baldwin, 2003).

A “whole system” approach has been advocated by a number of organisations as a way to tackle the abuse of older people (Action on Elder Abuse & Better Government for Older People, 2004) and promote the needs of older people (ADSS & Local Government Association, 2003). Whole system approaches can be applied to any intervention; from commissioning services for older people, to providing and evaluating training to social care staff, and it appears that consideration of the system as a whole is important in the area of health and social care (Antle, Barbee & van Zyl, 2008).

It is clear that the effect of safeguarding adults training is currently unknown, and similarly there has been little discussion of the facilitators and barriers to transferring safeguarding adults training. The question has not yet been directly addressed in any policy document to date, although CSCI reported that training was being put into



practice through supervision, observation of practice, and staff meetings. Supervision was generally used more in services with better star ratings. Furthermore the best service providers (defined by their quality rating) put a high value on safeguarding training, and managers regularly reinforced the message (Commission for Social Care Inspection, 2008a). These findings support ideas about the importance of transfer climate, supervision and reinforcement (the implementation aspect of training) which have been outlined in the training transfer literature (Burke & Hutchins, 2007) and again imply that the system, as well as the training that occurs within it should be evaluated.

### **3.3 Safeguarding adults training research**

While reviewing the literature for this study, only two published evaluations of safeguarding adults training were found. A national evaluation of the 'Tell Someone' project in Scotland used questionnaires and focus groups to measure pre and post training awareness and knowledge, and find out what actions had been taken as a result of the training (Dementia Services Development Centre, 2010), and is discussed in more detail in Chapter 8. The other paper used a randomised controlled trial design to compare the effectiveness of attending face to face training with reading educational material (Richardson, Kitchen & Livingston, 2002). The educational intervention aimed to improve the management of abuse of older people, and "effectiveness" was measured using responses to vignettes. Participants were asked to read a short scenario, and write down how they would respond to it. Two different sets of vignettes were administered pre and post training. Qualitative responses were scored according to a 'model answer' framework, and a 'learning' score was obtained by calculating the difference in pre and post test scores. People who attended the face

to face training were able to give a more comprehensive and accurate answer in response to the vignettes than those who received printed information.

The method of using vignettes was chosen because it allows the presentation of a number of different scenarios quickly, with little practical inconvenience (Richardson, Kitchen & Livingston, 2002). Vignettes have been used to measure the impact of corporate (Frisque & Kolb, 2008) and other health or social care based training programmes. These have included recognition of a mental health disorder by the public (Kitchener & Jorm, 2002) by government employees (Kitchener & Jorm, 2004) and by medical officers (Sriram et al., 1990), and recognition of indicators of child sexual abuse (Kleemeier et al., 1988). The method of using vignettes to test knowledge works well in these context, because it reflects applied learning which is what is required in practice, rather than simply learning facts.

Another study used vignettes to discover whether specialist medical training led to variation in diagnostic approach (Kalf & Spruijt-Metz, 1996). It asked participants from three medical disciplines to rank the salience of factors in each vignette that assisted them to make a diagnosis. This study raises an important advantage of using vignettes; they can serve as a way to determine which factors are important in decision making. This is a potentially important part of evaluating training as rather than simply requesting information about what people know, it gives the opportunity to find out what they would do when reacting to a particular system of influences. So, for safeguarding adults training, we could find out for example whether training makes people more likely to make an alert, even if it was about their best friend, as well as testing the impact of other systemic influences on behaviour.

### 3.4 Factorial surveys and safeguarding research

Factorial surveys have been used to investigate decisions around safeguarding and abuse, and have discovered useful points which were incorporated into the vignettes constructed for this study (see Methods chapter, section 6.3).

O'Toole and Webster (1999) aimed to discover the influence of the characteristics of the case, the participant and the organisational setting on the recognition and reporting of child abuse by teachers. The authors noted that recording both recognition and reporting of abuse was an important aspect of their study; recognition implies awareness of the problem, while reporting suggests an awareness that the problem is pressing enough to take action on. From a sample of 480 teachers, yielding over 11000 completed vignettes, they found that case characteristics accounted for over half of the variance of both recognition and reporting of abuse committed by the parent. The greatest effects were from type and seriousness of abuse, positive behaviour of the victim, and positive psychology of the perpetrator. These findings show that characteristics of the case can affect recognition and reporting of child abuse, raising the question of whether the same could be true for adult abuse. The perception of hierarchies of abuse is one that has also been identified in studies of adult abuse (e.g. Parley 2010). This study will explore this area further, in order to determine the factors (other than or additional to training) that determine recognition and reporting of adult abuse.

Lauder, Scott et al (2001) investigated the factors that influence nurses' judgements of self-neglect. Three groups were recruited: psychiatric nurses, student nurses and general nurses. Six dimensions were used that were perceived to influence judgements of self-neglect; the dimensions were selected after consideration of previous research

and theory in the field. 190 nurses participated with 1894 usable vignettes generated for analysis. There was no significant difference in rating between groups, and the spread of ratings suggested that self-neglect is perceived to be on a continuum of behaviours. Self-care status had the biggest influence on judgements of self-neglect, though it was still quite small; other patient characteristics including functional ability and psychiatric status also influenced ratings. The authors pointed out a possible flaw in factorial surveys, in that removing an issue (such as self-neglect) from its context “may obscure the very elements which differentiate nurses’ judgements” (pg. 605) whereas qualitative methods such as case studies or semi structured interviews may reveal more in depth information about how judgements are made.

Garret (1982) looked at the issue of child abuse in America which, in 1982, was poorly defined. This is similar to adult abuse in the UK now; she stated:

“Unlike most criminal legislation (which is often more exact in the definition of criminal behaviour) child abuse codes lack specificity. This lack of specific guidelines is reflected in policy manuals used by social workers... such vague definitions rely on the caseworkers’ discretion. He or she must determine the point at which acceptable child rearing practices have been violated, whether a particular action taken by a parent is actually ‘abuse’, ‘neglect’ or neither.” (pg. 178)

A factorial survey was used to ascertain the relative seriousness of various types of potential child abuse, and to provide a model of factors that influence the seriousness rating of an event. Respondents tended to rate at the high seriousness end of the scale. Seriousness was based on the knowledge of the abusive act and its consequences, the age of the child involved, and the characteristics of the child and guardian. However it was also found that consensus about seriousness was limited by the characteristics of participants; bearing in mind Garret sampled a wide sample of

the general public, more consensus might be expected in this study which only involves staff working in health or social care.

Recently, factorial surveys have received attention in the literature as a way to find out which factors affect the response to a safeguarding adults issue. One study looked at the factors that affect the detection of financial abuse of elders. The study found that, for health and social care staff, only 2 factors affected judgements; the mental capacity of the older person, and the nature of the financial problem suspected. The authors also recognised that evidence on the factors influencing this process can be used to inform professional training (Davies, 2011). Another study investigated the factors affecting judgements of elder abuse made by social workers, nurses, and other professionals in Northern Ireland (Killick & Taylor, 2011). The greatest influence to recognition was type of abuse, in terms of severity, and frequency of abuse also affected judgements. Including a variable about the consent of the victim to an investigation led to higher recognition of abuse than where such a variable was not included. The same three variables were significant influences on the decision to refer for an investigation- 72% of vignettes had identical recognition and reporting scores. 'Practitioner autonomy' referred to vignettes where the recognition and reporting score was different, and analysis showed this was influenced by the wishes of the client, as well as professional training.

There is some evidence that the organisational barriers to action that exist in reality have an effect on decisions made in factorial survey studies. O'Toole and Webster (1999) found that while the procedures for reporting in schools had no effect on the recognition or reporting of abuse by teachers in their factorial survey study, teacher's evaluations of child protective services were positively associated with both

recognising and reporting child abuse. This implies that some types of experience in reality affect actions taken in response to vignettes. Teachers' beliefs or fears about reporting, with some exceptions, did not affect their recognition or reporting of child abuse; neither did concerns about the process of responding. Higher reporting in the past was linked to higher recognising and reporting in the study. It seems quite clear that reporting will happen less frequently if it's more difficult to do it, which again implies that organisational barriers can moderate the effects of training, beliefs and values when reporting abuse.

### **3.5 Factors known to promote successful safeguarding**

Taylor (2006) recommends that a review of previous research be undertaken in order to determine the factors that should be included in the vignettes. The following section will outline how the requested demographic information and vignette factors for this study were decided on.

Although child and adult abuse have important differences, the literature has highlighted a number of factors that may prevent the reporting of child abuse that may also be applicable in an adult setting.

In terms of reporter characteristics, past experience, demographics, training, and education have all been found to influence reporting of safeguarding issues. Gunn et al (2005) surveyed paediatricians and found that male gender, years in practice and experience reporting were independently associated with decisions not to report, as were having reported more cases, to have been deposed, or to have been threatened with a lawsuit. Respondents who had declined to report after considering it were more likely to state lack of knowledge about reporting procedures and poor experiences of

child services agencies as reasons. In a study based in the USA, Daly and Jogerst (2005) found that a higher level of education was associated with a higher reporting rate, and that a greater knowledge of adult protection laws was associated with higher levels of reporting for directors of nursing. Conversely, professionals' lack of confidence in education about safeguarding services and interagency coordination (Wolf & Li, 1999) and in general (Cooper, Selwood & Livingston, 2009) were cited as barriers to reporting elder abuse. In a review of elder abuse, Kleinschmidt (1997) found that lack of consistent definitions was found to be a barrier to reporting. Health care professionals were unaware of available resources or felt they were inadequate; feared time constraints; were unfamiliar with reporting laws, and believed they lacked the required training; and were concerned with offending patients. There is, however, some evidence to suggest that training increases knowledge; Taylor and Dodd (2003) found that people with a recognised professional qualification, or who had attended training, were more knowledgeable; furthermore understanding of safeguarding issues and reporting abuse were correlated. Prior experience of managing cases of abuse, confidence in approaching external agencies for advice, and knowledge and understanding of safeguarding policies and procedures were all found to affect the way that managers respond to and deal with abusive care staff (Furness, 2006). This vignette study requested information from participants about the safeguarding adults training they had attended, their length of service in their current job and in the sector, their level of education, their job role, and their past experience of safeguarding adults.

Rapaport, Stevens et al (2008) used vignettes to facilitate debate over whether a staff worker should be put on the POVA (Protection of Vulnerable Adults) list (a list detailing

people barred from working with vulnerable adults due to misconduct) following an incident. Mitigating circumstances were discussed. The findings of this study may also provide an idea of circumstances which may provide a barrier to reporting, as if they are considered to be mitigating in terms of referral to the POVA list, an alert may be perceived as too strong a response. Managers were “particularly vociferous about the importance of ensuring that staff were properly trained inducted and supported” (pg. 12). This seems to suggest that abuse which is perpetrated by staff members with little support or training may not be reported; a lack of training may be a mitigating factor in abuse cases, despite the dearth of evidence about the effectiveness of training. A factor regarding status of the alleged perpetrator, including whether they had received adequate training, was included in the vignettes. Another factor concerned whether the alleged perpetrator had been seen to act in an abusive manner before.

Characteristics of the victim of abuse that may influence the reporting of elder abuse have been identified as including ethnicity, socioeconomic status and age (Wolf & Li, 1999), while Launder, Scott et al (2001) found that self-care status, functional ability and psychiatric status impacted on nurses’ judgements of self-neglect and lifestyle choice. This study included a factor concerning the reason that the alleged victim accessed services, and also their personality characteristics. Furness (2006) interviewed 19 managers and 19 residents in older people’s care homes to find out their views around issues related to inspection, regulation, and ways to better protect older people from abuse. When defining abuse, physical abuse was mentioned most frequently by managers, followed by verbal, financial and psychological abuse; this corroborates national findings on abuse reporting prevalence (The NHS Information Centre Social Care Statistics, 2011b). Sexual abuse was not mentioned, implying that it



may not be considered a risk to certain client groups, such as older people. 90% of managers had witnessed abuse in their working lives.

Characteristics of the case are also reported to influence reporting. Northway et al (2004) noted a perceived “continuum of severity” (p32) of abuse of people with learning disabilities. Although some staff asserted that “abuse is abuse”, others distinguished sexual abuse, physical abuse and sometimes financial abuse as more severe than other forms of abuse, and requiring a different response. Other authors have identified a ‘hierarchy of abuse’ (Jenkins, Davies & Northway, 2008; Parley, 2010). Parley reported that sexual and physical forms of abuse were generally thought to be “worse” than the other types, which were not identified as readily. Abuse was also associated with intent to harm, implying that abuse that is perceived to be unintentional may be underreported. There was also an implicit level of tolerance of abuse, where behaviour that was disrespectful or contemptuous, or “roughly handling people” (p. 22) was overlooked. Taylor and Dodd (2003) used qualitative interviews to investigate staff knowledge of issues around safeguarding in the UK. They found that 35% would only report abuse if it was “severe enough” (pg. 7) and 75% would only report if they had concrete evidence. Similarly, a meta-analysis of three American surveys that used the Elder Abuse Questionnaire found that a significant proportion of health professionals would not report abuse unless they were certain that it had occurred (Cooper, Selwood & Livingston, 2009). Perceptions of seriousness of abuse were also found to affect the way that care home managers responded to abuse (Furness, 2006). Furthermore, the early identification of abuse of people with a learning disability who live in residential settings may be hindered by an absence of

hard evidence (Marsland, Oakes & White, 2007). Type and severity of abuse were considered important factors to include in the vignettes.

Whistleblowing is another area of the literature that is relevant here. Research into the factors that prevent staff from “blowing the whistle” in a health and social care situation is fairly scant, however it is clear that peer and manager support is an important factor in allowing staff to speak up about concerns (Bjørkelo et al., 2008; Calcraft, 2007; Firtko & Jackson). Organisational culture has also been highlighted as a highly influential factor. Culture is widely accepted to mean a system of shared norms, values and assumptions (Schein, 1996) and is defined by Morgan as

“the pattern of development reflected in a society’s system of knowledge, ideology, values, laws and day to day ritual.” (Morgan, 2006, :120)

Morgan also writes that

“the development of organizational societies is accompanied by a disintegration of traditional patterns of social order, as common ideals, beliefs and values give way to more fragmented ones based on the occupational characteristics of the new society” (pg. 121)

This is interesting in terms of the types of abusive practice that have historically become engrained in institutions where vulnerable people reside; behaviour which would not have been acceptable outside of those institutions. Calcraft (2007, :23) states:

“While adult protection policies and professional values require workers to raise concerns about abuse, the culture within a team or within an organisation may discourage speaking out”.

The problem can be broken down into two parts; that of promoting the importance of making a safeguarding alert should abuse be encountered, and that of effectively managing the alerts that are received. A report by a whistleblowing advice line found that the highest volume of calls between 2002 and 2010 were from the care sector, while 13% were from health. The research implies that “the whistleblowing process is still not as straightforward and safe as it should be for those in the care sector” (Public Concern At Work, 2011, :2). Queries received related to how to escalate a concern, seeking reassurances, or dealing with victimisation for raising a concern. This implies the first part of the process is in need of further improvement in organisations.

The second part, how a concern is managed, is more difficult to comment on. Although data are now available from the NHS Information Centre on who is making alerts and what happens to them, they are not detailed enough to discern how well safeguarding is being carried out. The PCAW report found that 80% of care workers had already raised their concern when they called the helpline, and over a third of those concerns were initially ignored, mishandled, or denied by organisations. Whistleblowing policy or practice has also been identified as a recurring theme in serious case reviews (Aylett, 2008; Manthorpe & Martineau, 2011), and clearly still needs to be addressed.

Failings in the culture of care have been highlighted in numerous reports into abusive practice, not least the recent inquiry into deaths at Mid Staffordshire NHS Trust (Francis, 2010).

Calcraft (2007) details a number of inquiries and research findings highlighting the importance of support for people who whistleblow, and the influence of organisational culture on whistleblowing behaviour. Reports suggest that organisational factors, such

as treatment of the whistleblower and reactions to attempts to raise concerns, deter even experienced staff (Bjørkelo et al, 2008; Jackson et al, 1997).

Other authors have examined the factors within a culture that may promote abuse; this can include poor management and supervision, poor staff support leading to stress and high turnover, poor attitudes and values, poor training and consequently poor competence, and an imbalance of power between staff and residents (Marsland, Oakes & White, 2007). Marsland et al also describe the power of culture of staff teams, which may be supportive and cohesive, but equally may apply a social pressure to abuse while acting as a barrier to reporting concerns.

The vignettes used here included a factor about organisational culture, and one about the level of support for previous safeguarding concerns. This aimed to measure whether attending training has any effect on attitudes towards alerting in these circumstances. However, a disadvantage with vignettes is that they measure people's hypothetical actions rather than their actual actions, which may not be the same.

In summary, factors which appear to influence the reporting of abuse include the demographics, characteristics, experience and training of the reporter, characteristics of the victim, type and severity of abuse, characteristics of the alleged abuser, and workplace culture. Culture encompasses many issues, such as management and colleague support, openness to challenging, fear of whistleblowing repercussions, and relationships between staff.

### **3.6 A local perspective**

Because this research comprises a case study of Cornwall, it was decided to obtain a more local perspective on the factors influencing reporting, by asking members of the

Safeguarding Adults Board Training Sub Group and the Independent Chairs and Operational Leads of the Safeguarding Adults Unit to suggest what the barriers to reporting are in the county. The Training Sub group was made up of representatives from the local Primary Care Trust, Hospital Trust, Safeguarding Adults Unit, Adult Care and Support, and Independent sector. This exercise was not part of the formal research design, but acted more as a check of the applicability of findings from the literature review to the local context of Cornwall. The question was posed at a Safeguarding Adults Board Training Sub group meeting, where the researcher made notes of the responses; the notes were then emailed to group members to check that they were accurate, and to Independent Safeguarding Chairs and two Operational Leads who had not been present at the meeting, to offer them the opportunity to contribute. All four of the additional group contributed to the list of barriers.

These factors are shown in the table below, categorised into organisational, situational and individual factors. They correspond to the themes highlighted in the existing published research.

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<b>Organisational factors (Systemic barriers to reporting)</b>	<ul style="list-style-type: none"> <li>• Lack of response to alerts</li> <li>• Alerts being deflected between different agencies saying it isn't in their remit</li> <li>• Cost- especially for independent providers; suspension of alleged abuser on full pay can cripple smaller businesses; preferred route is to resolve issues internally.</li> <li>• Commitment of organisations to safeguarding</li> <li>• Defining institutional abuse on a form is difficult- no specific big event or perpetrator; whole system at fault</li> <li>• Existence of and adherence to a whistleblowing policy</li> <li>• Bad press regarding whistleblowing (case of nurse Margaret Haywood vs. NMC)</li> <li>• Workplace culture of alerter not feeling respected or supported</li> </ul>
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	<ul style="list-style-type: none"> <li>• Working in a “closed” institution, when service users and the professionals working with them may have little contact with the world outside of the organisation they live or work in.</li> <li>• Fear of management- when managers are informed of concerns but take no action or investigate “in house”</li> </ul>
<b>Situational factors (barriers relating to the case)</b>	<ul style="list-style-type: none"> <li>• Incidence of abuse (how many times they have witnessed it?)</li> <li>• Told not to alert- or that it isn’t as much of a big deal as they think</li> <li>• Complaints made about alerts made (wrongly or rightly) in the past, or during the process</li> <li>• Character of victim</li> <li>• Status of the perpetrator</li> <li>• Seriousness of abuse</li> </ul>
<b>Individual factors (barriers relating to the individual alerter)</b>	<ul style="list-style-type: none"> <li>• Fear of the unknown/ repercussions</li> <li>• (Lack of) knowledge and understanding, e.g. how to make alert or that they have a duty to</li> <li>• Doubts over whether report will be believed</li> <li>• Previous experience of the process not working well</li> <li>• (Lack of) confidence in the safeguarding process or their decision</li> <li>• Character of alerter</li> <li>• Beliefs over how much difference it would make if alert was made</li> <li>• Impact it will have on individual</li> <li>• Reluctance to disclose when the alleged perpetrator is a friend as well as a colleague</li> <li>• Perception of not having enough details.</li> <li>• Inappropriate boundaries with other carers/ families- perception that they’re doing their best.</li> </ul>

**Table 1: Factors identified as barriers to alerting**

Findings from the local group and findings from the literature corroborate each other, and were integrated into the vignette format. Training is only likely to be able to influence the individual factors relating to safeguarding, in the short term at least.

A number of other factors were considered which were drawn from policy and legislation. The Mental Capacity Act 2005 is central to the decisions and actions that

occur in safeguarding (Social Care Institute for Excellence & Pan London Adult Safeguarding Editorial Board, 2011) so a number of factors which required consideration of the Act were included. Consideration was given to the requests from potential victims of abuse not to take further action after a disclosure was made. The victim's perception of the perpetrator was also included as a factor that might influence alerting.

This chapter has outlined the importance of evaluating safeguarding adults training, and provided details of the development of one of the methods which will be used to evaluate training in this study. A full account of the methods that will be used in the study is given in Chapter 6.

Figure 1 on the following page shows the predicted impact of each of the factors on alerting, depending on whether training has been attended or not.

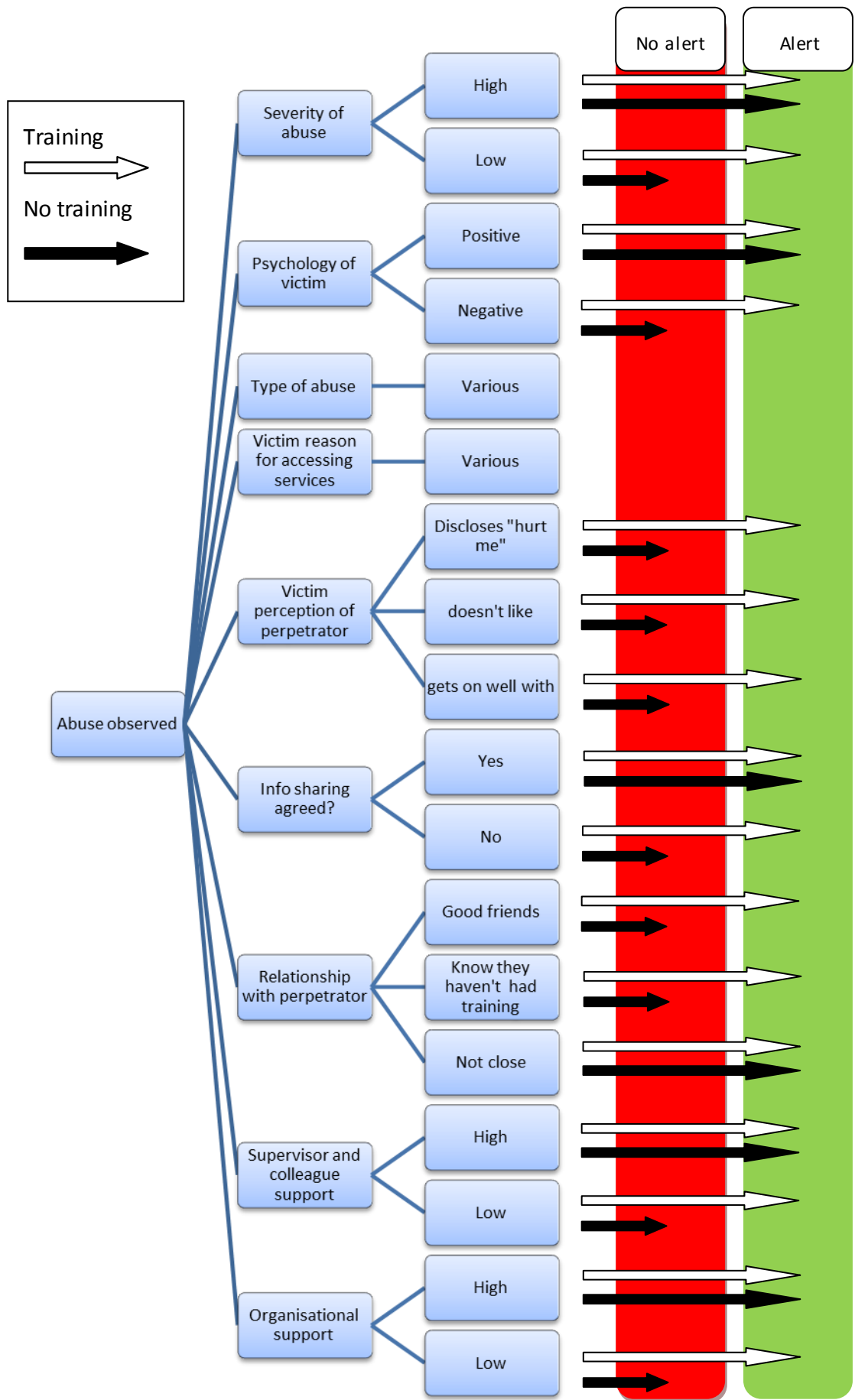


Figure 1: Predicted impact of each factor on alerting, by training attendance.



## Chapter 4 Identifying the safeguarding adults training programme theory

The preceding chapters have outlined some of the policy background of safeguarding adults, the contribution of safeguarding adults training to implementing that policy, and the importance of evaluating the training. This chapter looks at the policy makers' programme theory, or mechanism of action of safeguarding adults training; how exactly it is assumed to work to change practice.

### 4.1 Programme theories from policy

Some authors have outlined a threefold taxonomy of programme intervention, which includes carrots (economic means) sticks (regulation) and sermons (information) (Bemelmans-Videc, Rist & Vedung, 2007). Training clearly comes under the 'sermons' heading. Programme theories aim to develop understanding about what it is about a programme that makes it work. Pawson and Tilley (1997) expect programme mechanisms:

“(i) to reflect the embeddedness of the programme within the stratified nature of social reality; (ii) to take the form of propositions which will provide an account of how both macro and micro processes constitute the program; (iii) to demonstrate how program outputs follow from the stakeholders' choice (reasoning) and their capacity (resources) to put these into practice” (ibid: 66)

These tenets are reflected in the programme theories articulated below.

Clarke (in press) points out the considerable emphasis that is placed on workforce development to ensure improvements to quality of care provided in the UK. He asserts that a link between training and better services or care outcomes has historically been taken for granted, but there is growing recognition of the need for evidence to support this premise. Further analysis of training policy has identified that the need for ongoing

training and education for the social care sector has long been recognised, and has recently been reaffirmed internationally- yet despite this, the effectiveness of training as a means to promote changed practice is subject of fierce debate (Nolan et al., 2008). Commentators such as Nolan and Clarke have concluded that training is a necessary but not sufficient condition for change.

The mechanism of action for training was contained within *No Secrets*, the Section 7 guidance used in England to inform Safeguarding Adults practice. The implementation chain of safeguarding adults training is illustrated in the diagram below:



Figure 2: Safeguarding adults training implementation chain

The implementation chain and programme theories are different representations of the same thing- an explanation of how an intervention is meant to work. The chain above represents a high level outline of the mechanism by which training works. A closer reading of the relevant policies, outlined below, will elaborate on the specifics of the process by extracting programme theories from sections of policy text.

Elements of implementation other than training listed in *No Secrets* include clarification of roles and responsibilities in safeguarding, procedures and protocols, a dissemination plan, clarity over contractual expectations from care providers, a service development plan, and setting up and learning from the volume and outcomes of cases. It is implied that all the components are necessary for the strategy to be

implemented; by implication then, training alone is not sufficient to ensure that safeguarding is being carried out effectively.

\*Programme theory 1: Training works when it is carried out in conjunction with other safeguarding supports.\*

“Agencies should provide training for staff and volunteers on the policy, procedures and professional practices that are in place locally, commensurate with their responsibilities in the adult protection process...” (pg. 23)

\*Programme theory 2: Training works by increasing knowledge/ awareness (about procedures) which then results in changed practice\*

“...This should include:

- basic 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 investigators; and
- specialist training for managers

5.3 Training should take place at all levels in an organisation... To ensure that procedures are carried out consistently no staff group should be excluded...” (pg.23)

\*Programme theory 3: Training works by meeting people’s learning needs, through delivering it at a level appropriate to individual staff roles\*

\*Programme theory 4: Training works through shared knowledge, by ensuring that the whole system of people responsible for implementing it have attended and consequently have the knowledge of how to implement it\*

“Training should take place... within specified time scales....” (pg. 23)

\*Programme theory 5: Training works when providers create a strategy regarding who is to be trained when, and adhere to it\*

“...Training should include issues relating to staff safety within a Health and Safety framework...” (pg.23)

\*Programme theory 6: Training works by making staff feel valued (and hence increasing motivation) by discussing their health and safety\*

“...Training is a continuing responsibility and should be provided as a rolling programme.” (pg. 23)

\*Programme theory 7: Training works by repeatedly refreshing knowledge\*

Analysis of other safeguarding adults and social care policies was undertaken, to further develop the range of programme theories to consider.

#### 4.1.1 Safeguarding Adults (ADSS, 2005).

The ADSS document supports many of the programme theories implied in *No Secrets*. It again outlines training as a recommended element of an overall strategy, and cites “Training and supervision of staff and volunteers to promote quality standards of service delivery” (pg. 15) as a ‘relevant measure’. Training is cited as being able to bestow the appropriate knowledge of and competencies in relation to numerous safeguarding adults related topics. This articulates the outcome that training is meant to achieve (promotion of quality standards) but, again, not the mechanism by which it will achieve this.

\*Programme theory: safeguarding adults training promotes quality standards (by informing people of them?)\*

The training standards articulated in *Safeguarding Adults* outline the need for a workforce development plan, because “All people working in the organisation must be able to recognise abuse and neglect and know how to make effective reports” (pg. 19). This again makes an assumption that training will lead to improved knowledge and changed behaviour. The document also states that

“It is of great benefit if staff who will be liaising with colleagues in other agencies can take part in multi-agency courses that promote the understanding of the roles of other partners” (pg. 19).

\*Programme theory: multiagency training leads to multiagency working by facilitating understanding of others practitioners’ roles.\*

The notion of competencies that correspond to different job levels is expressed as a way to monitor and regulate behaviour. ADSS outline the importance of each organisation having an established safeguarding adults competency framework to base training standards on. This idea has been built on recently by Keith Brown and colleagues, who have devised a competency framework for safeguarding adults training and define a competence as,

“the combination of the skills, knowledge and experience held by individual staff and how they utilise these qualities to inform their practice in a way that is commensurate with their occupational role and responsibilities. To be competent you need to be able to interpret a situation in its context and to have a repertoire of possible actions to take. You will have been trained in the possible actions in the repertoire, where this is relevant. Regardless of training, competence grows through experience and the abilities of an individual to learn and adapt.” (Brown and Galpin, 2010)

\*Programme theory: Training contributes to competence in safeguarding adults by informing people of the possible actions to take in a safeguarding situation. Experience and the ability to learn are also needed to ensure competence.\*

Brown et al appear to recognise that training can contribute to competence, but is not sufficient to ensure it, and they emphasise the role that experience and ability play in ensuring competence. This is not articulated in *No Secrets*, or *Safeguarding Adults*.

While the training based structures in *Safeguarding Adults* appear to advocate programme theories similar to *No Secrets*, some other parts of the document imply a greater awareness of the systemic factors that can also help or hinder the promotion of safeguarding behaviours. Regarding partner agency systems, one standard states that,

“Each partner organisation ensures that staff and volunteers receive regular and recorded supervision that addresses ‘Safeguarding Adults’ issues and where there is an incident of alleged abuse or neglect, to debrief and reflect on practice. This should include the identification of and access to appropriate learning and development opportunities in this field” (pg. 27).

This implies that supervision may be more important than ‘training’ (termed learning and development here) in upholding the safeguarding adults policy. The phrase ‘appropriate learning and development’ leaves much more scope for interpretation and meeting of learning needs than the term ‘mandatory training’ as expressed elsewhere.

The issue of culture is mentioned in numerous good practice examples:

“There is an ‘open culture’ within partner agencies. This includes good communication between staff and managers and with all stakeholders, for example: regular feedback activities during which staff, volunteers, other

professionals, service users and carers can report on how the organisation is working in practice” (pg. 16).

\*Programme theory: Training works when it is supported by adequate supervision, communication, and other structures which promote an open culture\*

Again, this implies an awareness of structures other than training which can be used to promote effective safeguarding adults behaviour.

#### 4.1.2 Our Health Our Care Our Say (Department of Health, 2006)

The white paper Our Health Our Care Our Say outlined a vision for a more personalised health and social care system, with better preventative services, earlier intervention, more choice, less inequality, and more support for people with long term needs. The paper outlined that £5 billion was spent annually on training and developing staff in the NHS and social care, and stated that the way that money is spent would be reconsidered so more development is targeted at staff in support roles. The paper states, “It is not acceptable that some of the most dependent people in our communities are cared for by the least well trained” (Department of Health, 2006, :188), which implies that training equates to better quality of service. The paper also talks about developing competencies to ensure that workers can uphold the values of personalisation, and integrating the training and working of health and social care staff. There is no mention of the mechanism by which training is supposed to work; the implication, as outlined by Clarke (in press), is that training will lead to improved services, but there is no analysis of how this happens.

\*Programme theory: training will lead to improved services\*

### 4.1.3 Equality and Human Rights scheme (Care Quality Commission, 2010)

The CQC's consultation document on their Equality and Human Rights scheme states,

“We will promote a rights-based approach in everything we do, with a focus on outcomes for people – not on the processes used. This is more than just ensuring compliance – it is about changing attitudes and behaviours, organisational cultures and practices.” (Care Quality Commission, 2010, :11)

If this statement is applied to training, it implies a subtle change in approach, from assuming that adhering to a process- such as training staff- will result in better services, to acknowledging that outcomes, not adherence to process, are what matter. A change in inspection focus from ‘ensuring compliance’ in attending training, to questioning the outcomes of attending training, would be a positive step in moving away from the administrative model of training (where success is measured through attendance) currently active in the sector. CQC also state that as well as training staff, they will,

“ensure that they have the necessary support and the tools they need to understand their responsibilities and apply that knowledge in their work” (pg. 4)

Similarly to *No Secrets*, this implies awareness that training alone is not sufficient to ensure good practice. There is recognition that training is not the only action needed, and numerous action points are articulated. One of these is to “promote a culture whereby staff are valued, involved, supported and feel safe from discrimination” (pg. 15), which arguably relates to the topic specific culture as articulated in the model devised from the transfer literature. The CQC also outline key priorities of the scheme, in relation to their own organisation;



“Ensure that all staff are competent and confident in applying equality and human rights in their work, through implementation of an equality and human rights learning and development strategy (including mandatory training for all staff)” (pg. 15)

The implication is that training will make staff competent and confident in relation to human rights and equality issues; again, no rationale or mechanism of action is given. A consultation on this document apparently returned the view that training for CQC staff was “crucial to the successful implementation” of the scheme (pg. 17).

\*Programme theory: Training, provided in the context of other supports, leads to improved confidence and competence by improving staff knowledge.\*

#### 4.1.4 Governance in social care workbook (Somerset County Council and Social Care Institute for Excellence, 2011)

This workbook, based on practice in Somerset and Bath, is being promoted to other local authorities nationally as an example of best practice. The authors have made the need for a learning culture explicit.

“Good standards of practice will be achieved only if organisations have a learning culture that supports the training and development of staff. At an organisational level these developments address structures, culture, systems, human resources and leadership. At an individual level this means keeping up to date through training and post-registration training and learning.” (Somerset County Council and Social Care Institute for Excellence, 2011, :12)

This premise places the responsibility for service improvement in an arena much wider than ‘training’, into the realms of organisational learning. The document is also candid about the commitment that such a change will need;

“Developing the right culture is a major challenge that will take leadership, time and commitment from all levels of the organisation. This will develop only if there is a commitment to organisational learning, support for a fair and open

approach, and partnerships and collaboration with other professionals, people who use services and their carers” (Somerset County Council and Social Care Institute for Excellence, 2011, :8)

Again, this document shifts the focus away from providing training, mandatory or not, to staff, and towards more systemic issues not covered in policy documents.

\*Programme theory: Training works to achieve good standards of practice in the context of a learning culture\*.

## 4.2 Summary

Although the programme theories implied by *No Secrets* suggest that training alone is not sufficient to implement the policy, transfer and the importance of a positive learning culture or transfer climate is not mentioned. The government produces numerous policies concerning health and social care issues, and training is frequently posited as a way of implementing them. Understandably it is not the duty of policymakers to outline how to make training effective, but worryingly transfer is rarely, if ever, mentioned; it is possible that this lack of emphasis on the need to transfer, rather than just attend training, could contribute to a tick box mentality about training. It may be that policymakers assume that best practice in transfer is followed in the sector anyway, so no mention of it is needed, or that the assumption that training ‘works’ has not been interrogated sufficiently to warrant the mention of transfer.

The policies analysed do not consistently contain programme theories yielding information about context, mechanism and outcome of training; many of them only mention one aspect, and do not specify how the different components relate to each

other. To summarise, the elements of programme theories drawn from *No Secrets*, and other relevant English training policy outlined above are presented in the table below. The synthesis will investigate the relevant literature, to find out how these (or other) context- mechanism- outcome fragments are combined to result in successful training outcomes in health and social care.

<b>Context: Training works when:</b>	<b>Mechanism: Training works by:</b>	<b>Outcome: Training will achieve the outcome of:</b>
It is supported by supervision	Informing people of the possible actions to take in a safeguarding situation.	Good standards of practice/ promoting quality standards
It occurs as part of a learning culture	Repeatedly refreshing knowledge (reminding)	Improved confidence and competence of staff
It occurs as part of an open culture with corresponding structures	Ensuring shared knowledge of how to implement a strategy	Improved services
It operates in conjunction with other safeguarding supports	Making staff feel valued (increasing motivation)	Changed practice
It is part of a training strategy that targets all the necessary people	Meeting people's learning needs, through delivery at an appropriate level	

**Table 2: Table of context mechanism and outcomes extracted from English policy**

These fragments can be combined to produce an overarching programme theory; that if the workplace context is supportive and delegates are informed in a way that meets their learning needs, then outcomes of improved confidence and competence, and changed practice will be observed.

An amended diagram of the implementation chain, illustrating how the context, mechanism and outcome components relate to the implementation chain is shown in Figure 3. The findings of the systematic literature review and realist synthesis, and

then empirical work will be used successively to amend this programme theory, and clarify and evidence how the context, mechanism and outcomes are related, which may not be entirely as assumed by policy or the same in all settings.

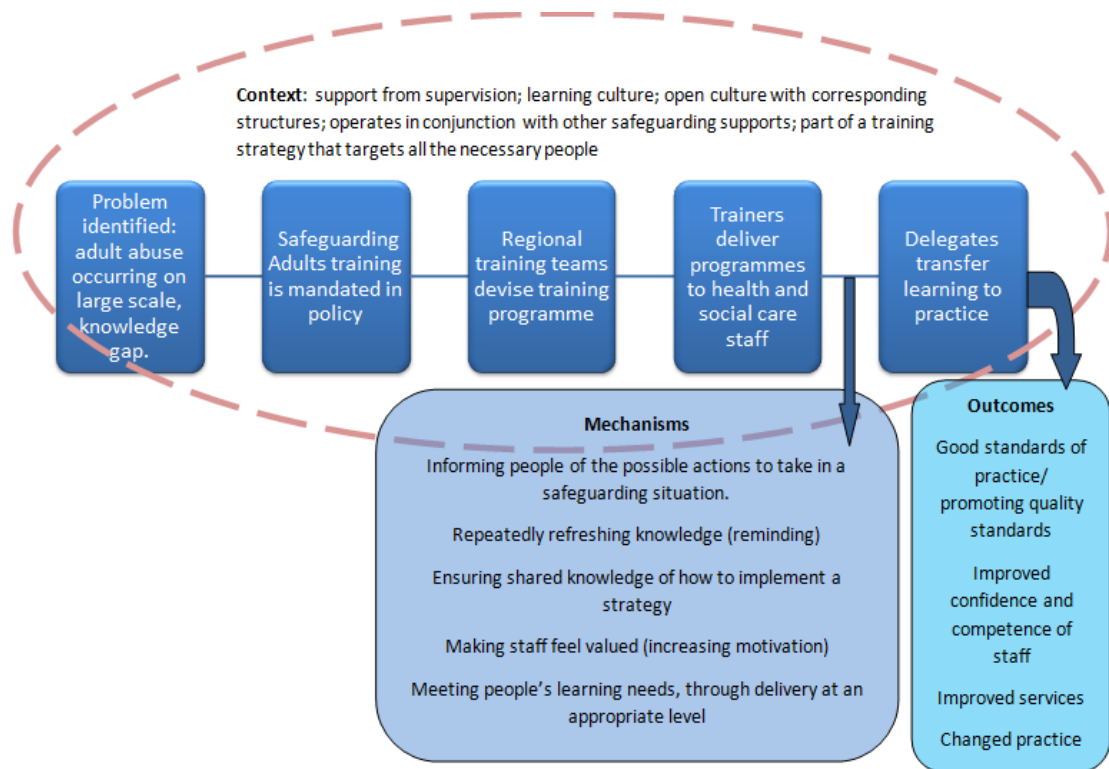


Figure 3: Relating the implementation chain to the CMO components: Initial model of policy makers' programme theory of safeguarding adults training.

## Chapter 5 Aims, objectives and research questions

The preceding chapters have outlined the problem of safeguarding adults, the issues raised by providing safeguarding adults training, the mechanism of action implied in the policy programme theory, and the challenge- and importance- of evaluating safeguarding adults training interventions. Adult abuse is acknowledged to be a significant and enduring problem in England and elsewhere. To address this problem, training has been mandated in policy. However, evaluations of safeguarding adults training appear practically non-existent in the academic literature; Manthorpe et al point out that

“despite the large amounts of money now being expended on training in this area, we have little knowledge of what training works and for whom, or its outcomes.” (Manthorpe et al., 2005, :31).

Despite the lack of attention given to safeguarding adults training transfer specifically, the training transfer literature generally is a large and growing body of work, although numerous areas have been highlighted as needing further attention. Burke and Hutchins (2007) made a series of research recommendations following their integrative review of the transfer literature; these included studying, within the realm of learner characteristics, learner metacognition (the ability for learners to self-monitor and regulate their learning strategies to maximise performance (ibid)) and goal orientation. In terms of intervention design, the authors recommended scrutiny of specific instructional methods “beyond active learning” (p284). Regarding work environment influences, attention was drawn to the need to investigate conceptual frameworks that inform the role of accountability in training transfer. More generally, they advised that transfer be used as the criterion variable (as opposed to transfer

intention, or learning) and that mixed methods approaches would benefit transfer research. Emphasis was put on the importance of a close relationship between research and practice in training transfer, with a suggestion that “best practice” should inform the research interests of academics so that such ideas can be empirically tested. Finally, Burke and Hutchins recognised that transfer is a multidimensional and systemic topic, which requires careful consideration of how best to capture and assess the factors affecting transfer.

These recommendations have informed the aims of this research, which looks at the mechanism of action by which safeguarding adults training impacts on practice. The dearth of research on effectiveness of the safeguarding adults training provided in England (or abroad), means that the facilitators of, and barriers to safeguarding adults training transfer are currently unknown.

The aim of this research is to identify, develop and refine a programme theory, or mechanism of action, of safeguarding adults training transfer. This will develop understanding about the factors that facilitate or inhibit the transfer of safeguarding adults training and address a gap in the research literature. It also has the potential to lead to practical recommendations that could impact on the wellbeing of people who use health and social care services in England, and elsewhere.

In accordance with this aim, the research objectives are:

- To outline the existing programme theory articulated in policy concerning safeguarding adults training
- To outline up to date knowledge on the factors that influence training transfer generally
- To narrow that knowledge down to social care training, and safeguarding adults training if possible

- As a case in point, to evaluate the impact of safeguarding adults training in Cornwall
- To identifying the barriers to, and facilitators of safeguarding adults training transfer.

Meeting these objectives will contribute towards answering the following research questions:

1a) What are the factors that are known to influence training transfer generally, and more specifically in social care?

b) What practical recommendations follow from these findings?

2 What effect do the Human Rights workshop and Safeguarding Adults Provider Managers' workshop have on delegates' practice, in terms of

a) thresholds to recognising and reporting adult abuse

b) actions undertaken in the workplace as a consequence of attendance on the workshop

2c) Considering the findings of a) and b), does the Manager's training add anything (in terms of actions taken or thresholds to recognising and reporting abuse) to the effect of the Human Rights workshop?

3) What factors in the workshops or workplace act as facilitators of or barriers to the transfer of learning from the workshop into practice?





## Chapter 6 Methods

### 6.1 Design

In their integrative literature review of training transfer research, Burke and Hutchins (2007) advocate the pairing of qualitative and quantitative methods to evaluate training. A mixed methods approach provides the opportunity to record both the narrative account of the mechanism of an effect through qualitative data, and the size of that effect through quantitative data. This is the approach that was used in this study, as neither the size nor the mechanism of action of safeguarding adults training transfer is currently addressed in the literature. Advantages of a mixed methods approach outlined by Blaikie (2010) include that the strengths of one method can offset the weaknesses in another, more comprehensive evidence is provided, it represents a practical approach as all possible methods can be used by the researcher, and it can help answer research questions where one method alone would not suffice.

This study used a mixed methods design, and took the form of a two-stage realistic evaluation where the 'programme theory' (Pawson *et al.*, 2004) of safeguarding adults training was identified, tested and developed. The programme theory identified in policy was first tested against secondary data obtained through a literature review of training transfer generally, and a separate review of social care training. The theory was then refined according to literature review findings, and tested again in a specifically safeguarding adults training context against primary data collected in Cornwall, using a cross sectional case study method. Findings from the empirical research informed an amended programme theory of safeguarding adults training transfer. The three methods which were used to address the research questions and develop the programme theory are outlined in the table below.

Research question:	Method of addressing research question:
<p><b>1a) What are the factors that are known to influence training transfer generally, and more specifically in social care?</b></p> <p><b>b) What practical recommendations follow from these findings?</b></p>	<p>A systematic literature review brought an earlier integrative literature review of general training transfer (Burke &amp; Hutchins, 2007) up to date. A second search was conducted using evidence on health and social care training. Finally, a realist synthesis approach used the review findings to revise the policy makers' programme theory of safeguarding adults training, and outline practical recommendations.</p>
<p><b>2a) What effect do the Human Rights workshop and Safeguarding Adults Managers' workshop have on delegates' practice, in terms of thresholds to recognising and reporting adult abuse?</b></p>	<p>A cross sectional factorial survey measured thresholds to recognising and reporting abuse, using training as an independent variable. The survey highlighted the factors in a safeguarding situation that are most influential in the recognition and reporting of abuse, and showed the impact of training on recognition and reporting thresholds. The survey also contributed to developing a programme theory of safeguarding adults training transfer.</p>
<p><b>2b) What effect do the Human Rights workshop and Safeguarding Adults Managers' workshop have on delegates' practice, in terms of actions undertaken in the workplace as a consequence of attendance on the workshop?</b></p> <p><b>3) What factors in the workshops or workplace act as facilitators of or barriers to the transfer of learning from the workshop into practice?</b></p>	<p>Narrative analysis identified the impacts of attending the programmes and factors in the workplace that helped or hindered safeguarding adults training transfer.</p>
<p><b>2c) Considering the findings of 2a) and 2b), does the Manager's training add anything (in terms of actions taken or thresholds to recognising and reporting abuse) to the effect of Human Rights workshop?</b></p>	<p>The level of training that participants had attended was used as an independent variable in analysis. Interviews from the two levels of training programme were analysed separately before results were combined using a retroductive approach.</p>

Table 3: Methods used to answer the research questions

Triangulation has been recommended in the training transfer literature as a way to obtain the most reliable evidence about the impact of a training programme (Burke & Hutchins, 2007; Burke & Hutchins, 2008), although in a systematic review of interprofessional education, Hammick et al (2007) found that only 3 studies out of 884 incorporated some element of triangulation. In a study investigating the effectiveness of time management training, Green and Skinner (2005) triangulated data from delegates with data from their managers. There was a 95% agreement on the figures; this suggests that concerns about the inaccuracy of self-reports from delegates in training in evaluations may be unfounded, but shows the value of triangulating data. Viewing various sources of data has also been found to help identify any biases in the sample (Manthorpe et al., 2007). As well as allowing triangulation, mixed methods approaches have the potential to facilitate the synthesis of findings from different methods to create a different kind of understanding of a problem.

Although it could be argued that a randomised controlled trial would be the strongest design for this area of research, there are numerous reasons why the method was not used for this study, which investigated the effects of a training intervention. Obtaining baseline data from staff from numerous organisations to collect “before” and “after” training results could not be done within the scope of this study due to resource constraints. High staff turnover in the sector (Eborall, 2010) would make it difficult to ensure that any particular staff member attended a particular course on a particular day. Identifying sufficient numbers of staff who are shortly to participate in training, and are willing to participate in a study would be very challenging.

Problems with using randomised controlled trials in the context of social work research were outlined by Morago (2006). He argued that genuine random allocation is difficult

in certain real world situations, and that contamination across groups can easily occur, where the study group can transmit the content of the intervention to the control group. This can easily be applied to the topic of social care training, where it is likely that the effect of training will spread from an experimental group to the control peers, due to the proximity in which the groups work.

Morago also outlined a flaw regarding using randomised controlled trials to evaluate interventions; that they do not establish what aspect of the intervention caused the effect. This is especially pertinent to the issue of training transfer, where the literature has demonstrated the effect of factors relating to delegates, the training intervention, and the workplace environment; stating that x intervention is better than y, without knowing what contributed to the effect, has limited use.

A repeated measures design was also decided against because practice effects could bias results. Although a control group could overcome the problem, this was considered impractical due to resource constraints. Furthermore, context may play a role in safeguarding behaviours, and the national context of safeguarding cannot be held at a constant over time. The BBC Panorama programme about Winterbourne View (*Panorama*, 2011) is one example of how news and media coverage can affect the attention given to a subject such as safeguarding. Previous work in this area has found low response rates to requests for participation in research (Pike *et al.*, 2011), and high attrition rates would be expected in line with the high turnover of staff in social care. The systematic literature review carried out as part of this study showed that while longitudinal designs are more rigorous, practical constraints result in most transfer research being cross sectional.

Even when feasible, experimental studies such as randomised controlled trials should be supplemented with qualitative data to determine the mechanism of action in training transfer research. A cross sectional, mixed methods design will therefore be used instead, as this eliminates the problems associated with a natural experiment and will provide comprehensive data with which to understand the mechanism of action of safeguarding adults training. The methods, including a systematic literature review with realist synthesis, factorial survey and semi structured interviews were used to answer the research questions which are outlined under the appropriate method. Ethical considerations are outlined at the end of the chapter.

### 6.1.1 Sampling: Choice of study site

The research was carried out in a single county, Cornwall, due to the practical constraints of following a Knowledge Transfer Partnership (KTP) project that was situated in the county. Much of the preliminary work for the research was carried out during the KTP project, which also enabled the researcher to gain an in depth understanding of safeguarding adults training provision in Cornwall, through working in the training unit of Adult Care and Support at Cornwall Council. The contextual features relevant to the study are outlined in section 2.12.

While Cornwall may be atypical in that safeguarding has had a high profile in recent years, the policies and procedures that it works under are not. Stanley et al (2011) found that safeguarding policy and procedure documents from 21 local authorities and NHS Trusts across the UK, including Cornwall, were not very different from one another, and were influenced both in form and content by *No Secrets*. Generalisability of this study may be improved by the fact that safeguarding adults practice nationally is based on a centrally generated policy. Furthermore a review of 10 cases of disability

related harassment concludes that much of the learning in Cornwall (from Steven Hoskin's murder) is applicable to other areas of Britain (Equality and Human Rights Commission, 2011b).

There are some advantages in conducting the study in a single county. All organisations in Cornwall work under the same safeguarding adults process, meaning there is no need to control for the influence of different administration of the process in different counties. Because of Cornwall's geographical isolation, there is little cross contamination of practice, or practitioners, from neighbouring counties. Cornwall's geographical characteristics and unitary authority (Cornwall Council) controls for factors which would be difficult to identify and control over a multisite study.

Details of the sampling strategy and sample for the factorial survey can be found in sections 6.3.8 and 6.3.9. Details of the interview sampling strategy and sample can be found in section 6.4.4.

## **6.2 Systematic literature review with realist synthesis**

### **6.2.1 Introduction: the realist synthesis method**

A systematic literature review using a realist synthesis approach was chosen to address research question 1:

1. a) What are the factors that are known to influence training transfer generally, and more specifically in social care?
  - b) What practical recommendations follow from these findings?

The literature review involved two elements; first a search of the general training transfer literature was carried out, using the methodology from Burke and Hutchins (2007). Burke and Hutchins are prominent authors in the field of training transfer, and

their review has been cited 166 times (Google Scholar to January 2012). To identify the factors known to influence training transfer specifically in social care, a second search was conducted. The findings of both searches were then compared against the programme theory of safeguarding adults training that is articulated in policy, using a realist synthesis approach. In realist synthesis, the search methods are the same as for other types of review but the aim is to test the identified programme theories against relevant evidence (Pawson *et al.*, 2004).

While systematic reviews aim to minimise bias by using explicit and systematic methods (Higgins, 2008), some challenges have been outlined in using them in relation to the medical education literature (Haig & Dozier, 2003), which is comparable to the social care training literature because there are few comprehensive sources dedicated to the subject. Haig and Dozier identified the issues of sensitivity- the percentage of known citations pertaining to the search query that is retrieved by a search- and specificity- the percentage of retrieved articles that are relevant to the search- as problematic. They found that sensitivity ranged from just 6.5- 19.6%, while specificity ranged from 6-34%. This makes systematic searching of journals a laborious process that frequently does not yield a comprehensive picture of the research. By using a realist synthesis approach this disadvantage becomes less problematic, because the aim is not to create an exhaustive picture of all evidence, but rather to gather and analyse enough evidence to inform and develop the programme theory.

Systematic reviews often aim to find out 'what works', without paying heed to the context in which interventions operate. Context has been shown to be an influential factor in the effectiveness of complex social interventions, and the effects of the

workplace are well documented as having an impact on transfer. Realist synthesis is defined as

“an approach to reviewing research evidence on complex social interventions, which provides an explanatory analysis of how and why they work (or don’t work) in particular contexts or settings” (Pawson *et al.*, 2004, :iv).

It acknowledges that interventions are applied to complex systems containing a variety of factors that could potentially influence the effectiveness of the intervention, and goes on to state that these factors are the “single greatest challenge to evidence based policy” (ibid: 7) as generating transferrable lessons about interventions which are embedded in different structures is very difficult. The seven key characteristics of complex social interventions, and reason for classifying safeguarding adults training as one, are provided in Appendix C . An example of realist synthesis was provided in the form of a review of staff training in adult social care, carried out by research in practice for adults (ripfa) on behalf of the National Skills Academy (ripfa, 2010).

Integral to the realist synthesis approach is the expression of a number of programme theories, which are then tested. Programme theories are ‘mechanisms of action’; underlying rationales about how an intervention is supposed to work which use the general format, “providing resource X will change outcome Y because...” (Pawson *et al.*, 2004, :16). A crucial part of a realist synthesis is therefore to identify and refine implicit programme theories from policy and the literature, with the ultimate aim of finding out “what works for whom, in what circumstances, and how?” (ibid: v).

Realist synthesis is a relatively new method and consequently has no set standards or guidelines to work within although work is currently underway to devise some (Greenhalgh *et al.*, 2011). This study made use of the existing literature about realist



synthesis, along with examples of realist reviews (e.g. Dieleman et al., 2011; Pawson, 2004) to guide its implementation. Use was also made of the RAMESES Jiscmail email forum, which gave an opportunity to pose questions about realist review to its creators.

### 6.2.2 Search 1: Systematic literature review based on Burke and Hutchins (2007)

This search addressed the training transfer literature as a whole. Burke and Hutchins' integrative literature review aimed to find out, among other things, which variables have exhibited strong empirical support for transfer outcomes, what methodological progress has been made, and how future research should proceed. An integrative literature review is

“a form of research that reviews, critiques, and synthesises representative literature on a topic in an integrated way such that new frameworks and perspectives on the topic are generated” (Torraco, 2005: 356).

Such reviews usually aim to either reconceptualise mature topics, where the literature has developed significantly since the last conceptualisation, or work on new topics to give them a conceptual framework.

Burke and Hutchins' review was focused on empirical findings grounded in theory and assessed through peer review. This review therefore stipulated peer review as a search criterion. Disciplines searched included management, Human Resource Development, training, adult learning, performance improvement and psychology.

### 6.2.3 Search 1: Inclusion criteria

To be included, studies had to provide a description of the transfer construct either explicitly, or through other information provided in the paper that indicated that transfer was the criterion of interest. Transfer was defined as, “the use of trained knowledge and skills on the job” (Burke and Hutchins: 265). This review also included studies that stated either transfer motivation, or transfer intention as the criterion of interest.

The keywords *transfer of training*, *transfer of learning*, *training transfer*, *skill maintenance*, and *skill generalisation* were used in the search which included the online databases Business Source Premier, PsycInfo, and ERIC (Educational Resource Information Centre). Although Burke and Hutchins also searched Business Source Complete, Academic Source Premier and Professional Development Collection, due to time and resource limitations these databases were not searched. Papers from 2005 to 2010 were searched in order to bring the evidence base described in Burke and Hutchins up to date.

The authors were contacted to request further details of the search strategy and screening tools. One author replied that all relevant information was contained in the paper, and that she could not recall a screening tool being used. The search strategy is outlined in Appendix D . A screening tool (see Appendix E ) was therefore created for this review based on the information contained in the paper, further developing Burke and Hutchins’ methods. Papers met all of the following criteria;

- Peer reviewed
- Meta-analysis, or based on empirical findings (including qualitative work with a theoretical lens)

- Addressed learning characteristics, intervention design or delivery, or work environment influences
- Defined the transfer construct explicitly, or give another indication that transfer is the criterion of interest

While this review was being carried out a metaanalytic review of 89 empirical training transfer papers was published (Blume *et al.*, 2010). The paper aimed to provide a comprehensive analysis of the predictors of transfer of training, in response to a number of qualitative reviews (including Burke and Hutchins (2007)) which had found contradictory results. They defined transfer as,

“consisting of two major dimensions: (a) generalization- the extent to which the knowledge and skill acquired in a learning setting are applied to different settings, people and/or situations from those trained, and (b) maintenance- the extent to which changes that result from a learning experience persist over time.” (p1067).

The researchers also took account of a bias present in the transfer literature which they argue can inflate effect sizes. Same Source (SS) and Same Measurement Context (SMC) bias occur when measures for more than one variable (e.g. supervisor support and transfer) are taken at the same time or from the same person. The authors aimed to estimate effect sizes that do not reflect this bias, but found that the SS/ SMC measurement bias consistently inflated the relationships between the constructs examined. This has important implications for future transfer research, in that constructs should be measured at different times, or from different sources. Many of the papers including in this review did not take account of this.

#### 6.2.4 Results of the search

The table below shows the numbers of papers retrieved from each search. “Transfer of learning” was searched last in the Psycinfo database, and due to the large

number of papers which were irrelevant or duplicated previous searches, only the first 100 (in order of relevance) were considered. Only 2 new papers were retrieved from the 100 searched.

	<b>Transfer of training</b>	<b>Transfer of learning</b>	<b>Training transfer</b>	<b>Skill maintenance</b>	<b>Skill generalisation</b>	<b>Learning transfer</b>	<b>Total</b>
<b>Psycinfo</b>	176	(751) 100	289	77	17	294	953
<b>Bus Source</b>	83	62	32	1	0	42	220
<b>ERIC</b>	67	10	7	8	0	1	93
							1266

**Table 4: Number of papers found from the general literature search**

Of the 1266 papers identified, once duplicates were removed, 199 (16%) passed the initial screening stage and progressed for further analysis. 7 were removed due to their inclusion in the original review, leaving 192. The 192 papers were then examined a second time using the screening tool based on Burke and Hutchins’ search criteria.

90 papers were included in the final review. This fairly high number (compared to Burke and Hutchins’ 170 inclusions with no limitations around publication date) reflects the fact that the training field has grown “exponentially” in the last decade (Aguinis and Kraiger, 2009: 452). A PRISMA flow chart of the process by which the literature was selected is included below.

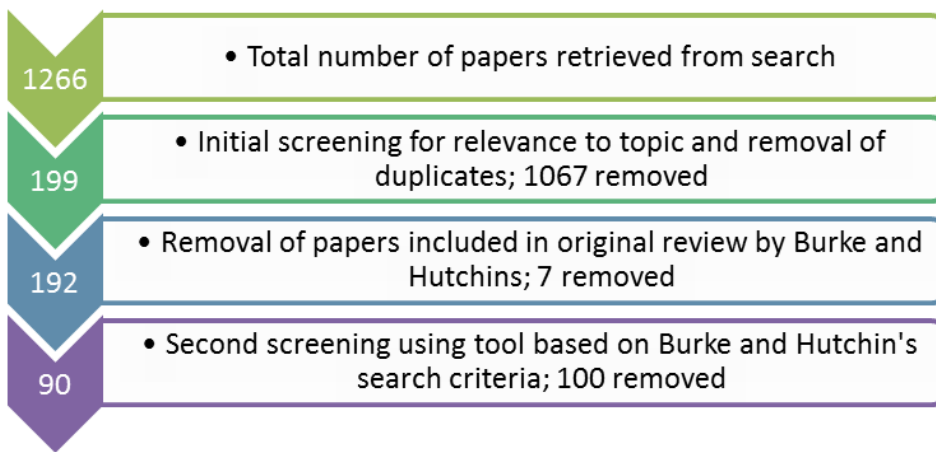


Figure 4: PRISMA flow chart of selection of the general transfer literature

To check the overlap of papers included in both reviews, the references of Blume et al's paper were compared with the 90 studies included here. Blume et al's review included 12 papers published after 2005 which were not found in this search; this included 8 studies that did not meet the inclusion criteria (5 conference papers and 3 unpublished doctoral dissertations). 9 papers were included in both reviews.

A taxonomy of the three conceptual factors influencing transfer- learner characteristics, intervention design and delivery, and work environment influences- was used to structure Burke and Hutchins' review, and a similar framework was used here.

### 6.2.5 Search method 2: Social care training transfer search.

This section will detail the stages of the search that led to the identification of evidence to include in the realist synthesis.

A systematic literature review search method was initially used to address the topic of training transfer in social care, by searching the terms, "safeguarding adults", "adult protection", "safeguarding adults training", "adult protection training", and "social care training", including wildcard searches. The databases Psycinfo, Business Source

Premier, ERIC and Social Care Online were searched. This aimed to build on Clarke (in press)'s paper which looked at the link between training and quality of care, identifying papers that evaluated in-service training in social care published between 1998 and 2010. Papers from 1980- present were identified; this time frame identified papers contemporary to and following the seminal work by Baldwin and Ford (1988), whose conceptualisation of factors that influence training transfer into three categories of individual characteristics, training design and delivery, and work environment influences has been widely used in the transfer literature.

Inclusion criteria used in the social care focussed search were adapted from Clarke (2001) and outlined below:

- Training programmes identified must be specifically for health or social care training, defined as training and development programmes addressing issues relevant to people working or volunteering in health, social care or related sectors (e.g. housing, police).
- Training on issues that concern medical procedures will not be included
- Studies should specifically focus on and provide results from an empirical evaluation of a training programme (therefore outlining training transfer) and not merely describe training and suggest possible evaluation strategies (Clarke, 2001, :759).

Only English language papers were considered.

### 6.2.6 Results from the search

Table 5 below shows the number of hits from each search. Of the 290, 91 were retrieved for further review. The remainder were discounted because they did not meet the criteria of being peer reviewed, and addressing the topic of social care training. Of the 91 retrieved, only 28 had training as a primary concern, and of those, only 4 described an evaluation of a training or development program.

This search focussed specifically on safeguarding adults training, and correspondence with researchers in the field of safeguarding adults reinforced the impression that no evaluations of safeguarding adults training have been published to date. However two papers were found through a reference search and a personal contact (Dementia Services Development Centre, 2010; Richardson, Kitchen & Livingston, 2002).

	Safeguarding adults	Adult protection	Safeguarding adults training	Adult protection training	Social care training	Total
<b>Psycinfo</b>	14	142	86	1	7	250
<b>Bus Source</b>	1	1	0	0	0	2
<b>ERIC</b>	0	0	0	0	1	1
<b>Social Care Online</b>	13	23	0	1	0	37
						290

Table 5: Number of papers found from the social care literature search

A PRISMA flow chart of the selection of the literature is below.

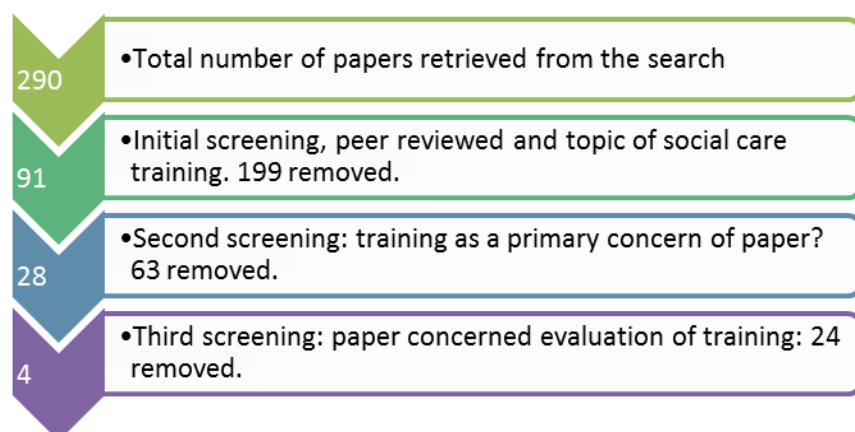


Figure 5: PRISMA flow chart of selection of the social care transfer literature

Due to the limited amount of evidence obtained from the social care search, alternative methods were used to add to the evidence to use in the realist synthesis. Fifteen papers identified in search 1 were included because they focussed on either health or social care training. References were sought from a paper reviewing the link between training and quality of adult social care (Clarke, in press). Grey literature was also sought; this is defined as

“That which is produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers” (Haig & Dozier, 2003, :356)

The author contacted safeguarding adults training providers (LSIS, Jacki Pritchard, Outlook UK, Safeadult), government officials (Department of Health) and other relevant organisations (Social Care Institute for Excellence, General Social Care Council, Association of Directors of Adult Social Services, Association for Care Training and Assessment Network, Care Quality Commission, National Skills Academy, research in practice for adults (ripfa)) requesting whether they were aware of any evaluations of social care training. Requests did not generally yield any evaluations. Responses on the ripfa forums resulted in some links to training evaluations that had been carried out by local authorities (though not for safeguarding adults). Discussion with contacts on Twitter led to the discovery of a national evaluation of safeguarding adults training programme that had been carried out in Scotland. Other references were obtained from Zetoc alerts for the terms training transfer, training effectiveness, training evaluation, learning transfer, safeguarding adults, and alerts for specific journal titles (see Appendix F ).



### 6.2.7 Selecting material for inclusion in the realist synthesis: Assessing quality of evidence

Systematic literature reviews, some argue, endorse the concept of hierarchies of evidence (Reed et al., 2005), with some elements of the medical literature listing an RCT design as a criteria for inclusion. Reed (2005) outlined the main problems with using randomised controlled trials in the arena of educational research, highlighting the practical considerations that make carrying out an RCT in an organisation very challenging. Although RCTs are considered the “gold standard” by some, other authors have argued that social care knowledge should have no implied hierarchy and that “all types of knowledge deserve equal respect and attention” (Pawson, 2003b, :1). Therefore efforts were made to collect a wide range of evidence for the realist synthesis, while assuming no hierarchy of knowledge.

Realist synthesis acknowledges that the literature on service interventions can be epistemologically complex and methodologically diverse (Pawson *et al.*, 2004). Although safeguarding adults training evaluation has received very little attention in the research literature, it is possible that local authorities or training providers may have carried out evaluations which have not been published. The wide range of methods used in research into training evaluation means that it is harder to synthesise evidence from a review using systematic review methods, as reviewers cannot compare like with like. Whereas SLRs would appraise the quality of evidence using predetermined criteria for studies which use the same methodology, realist reviews must make the best of using evidence which in some cases (such as the grey literature) has no quality criteria. Judgement and discretion is needed to ensure that evidence included has relevance (i.e. addresses the programme theory being tested) and rigour

(ensuring that the inference drawn by the author can make a credible contribution to the review) (ibid). Reed et al (2005) outlined a number of methods for assessing study quality but also pointed out that quality of reporting can obscure quality of the actual study, using different quality rating tools can lead to different assessments of quality, and reviewers have the potential to introduce bias. The value of using “quality criteria” can therefore be questioned, making Pawson et al’s approach of commenting on relevance and rigour seem a sensible course of action. However, another approach to appraising the quality of a diverse range of material was proposed by SCIE, who advocated the TAPUPAS model for assessing evidence from a range of sources (Pawson, 2003a). This acronym stands for-

- Transparency- is it [the evidence] open to scrutiny?
- Accuracy- is it well grounded?
- Purposivity- is it fit for purpose?
- Utility- is it fit for use?
- Propriety- is it legal and ethical?
- Accessibility- is it intelligible?
- Specificity- does it meet source specific standards?

These generic standards are endorsed by the authors as being of value to systematic reviewers in the social care field, where the inclusion or exclusion of material on the basis of strict methodological criteria is often problematic. These standards will also be considered when appraising the evidence for the realist synthesis, although most evidence was obtained from peer reviewed studies, as grey literature was hard to find.

### 6.2.8 Data extraction

Data extraction is “the process by which researchers obtain the necessary information about study characteristics and findings in the included studies” (Centre for Reviews and Dissemination, 2008, :28). The data for the systematic literature review were extracted using a data extraction form (see Appendix G ). The realist synthesis method acknowledges that a highly structured method such as this may be unsuitable for appraising evidence from a wide range of sources, and recommends note taking instead. However, an amended version of the data extraction form was used, as it provided a straightforward system of recording observations about the program theories, as well as about context and mechanism. The amended data extraction form can be found in Appendix H .

### 6.2.9 Synthesising the data

Findings from the systematic literature review were presented using the format of Burke and Hutchins (2007), by grouping factors that influence transfer into individual characteristics, training design and delivery, and workplace factors. Factors were then mapped onto a diagram, which illustrated some key relationships at work in training transfer generally. Programme theories from safeguarding adults training policy were then identified (see Figure 3), and causal propositions were articulated. These causal propositions provided the framework for structuring and combining the findings of the realist synthesis (search 2). Evidence supporting and challenging the programme theory was outlined, and a revised programme theory was articulated and expressed (see Figure 10). Causal propositions from this theory were used to synthesise findings from the empirical research carried out in Cornwall, resulting in the final programme theory (see Figure 25).

## 6.3 Factorial survey

A factorial survey method was chosen to address research question 2a:

**Research Question 2:** What effect do the Human Rights workshop and Safeguarding Adults Managers' workshop have on delegates' practice, in terms of

a) thresholds to recognising and reporting adult abuse

### 6.3.1 Design.

A factorial survey was used to provide a cross sectional comparison between people who had attended different levels of training.

Independent variables were training attended, demographics, past safeguarding adults experience, and content of vignettes shown to participants. Dependent variables were responses concerning the recognition and reporting of abuse, and confidence in doing so (see section 6.3.11).

### 6.3.2 What are factorial surveys?

Factorial surveys provide a way of investigating which factors are most important in making decisions where multiple factors may influence the outcome. They are a means of uncovering the shared and distinctive principles of social judgements (Rossi & Nock, 1982). The method has also been recognised as a valid yet underused means to better understand the complexities of professional decision making (Lauder, 2002; Taylor, 2006; Wilks, 2004) as it allows people to discuss sensitive topics in a depersonalised way (Charles & Manthorpe, 2009). As a potentially powerful but underused method, the use of factorial surveys in uncovering the mechanism of professional decision making has been highlighted (Taylor, 2006) and the method has also been used to investigate the decisions of professions such as nurses in numerous studies (Lauder,

Scott & Whyte, 2001; Ludwick et al., 1999; O'Toole et al., 1993). Some examples of topics covered in past factorial survey research are factors that influence decisions about the acceptability of medical errors by patients (Schwappach & Koeck, 2004), recognition and reporting of child abuse by teachers (O'Toole *et al.*, 1999), and nurses' judgements of self-neglect (Lauder, Scott & Whyte, 2001).

### 6.3.3 How are factorial surveys used?

The method entails creating a number of vignettes (scenarios) from a combination of predetermined factors which the researcher has reason to believe will have a bearing on the judgement made. For this reason, an at least tentative understanding of the problem to be evaluated should be held before a factorial survey is undertaken (Rossi & Nock, 1982). Factors should be orthogonal (independent of each other), although Charlton (2002) points out that there is usually some correlation between factors in real life, and results may be less clear cut. As mentioned above, the process of generating vignettes is done by randomly selecting factors to combine which make up the scenario, meaning that the variables are orthogonal in the survey (if not completely in real life). Factorial surveys help to model the decision making process of individuals; and in order to model it, the influencing factors should be postulated beforehand.

The scenarios are then presented to participants, who are asked to make a judgement about either what they, or the protagonist should do in that situation. Judgements are generally made using numerical scales with descriptive anchors at either end (e.g. in the case of reporting child abuse, from 1 ("unlikely to report") to 9 ("likely to report") (O'Toole et al, 1999)). Participants are usually presented with a number of vignettes to rate (available literature shows this can range from 1 vignette (Applegate et al., 1996)

to 64 (Garrett, 1982); see Appendix I ), and also provide demographic information that may influence their choice of action, such as job title, length of service, or level of qualification. Characteristics of participants, and the presented vignettes, are then analysed using some kind of multiple regression to determine which factors have the greatest effect on the resulting judgements.

#### 6.3.4 Advantages and disadvantages of factorial surveys

An advantage of using factorial surveys over descriptive or hypothesis testing surveys is the ability to include a wide range of different factors and levels, more accurately reflecting the complex mix of influences that affect our decisions in the real world. In a factorial experiment, participants are asked to judge all possible combinations of factors, which limits the number of factors that can be included in the design. Factorial surveys, on the other hand, allow the presentation of a sample of the 'vignette universe', which allows a larger number of factors to be included (Wallander, 2009).

Wallander (2009) explains that presenting participants with concrete and detailed descriptions where the factors believed to influence the decision are systematically varied makes the approach well suited to studying the contexts and conditions that affect judgements. However, higher numbers of factors and levels lead to greater numbers of potential vignettes, thus either increasing the number of vignettes that need to be completed by participants or increasing the size of confidence intervals (Charlton, 2002). Tabachnick and Fidell (2007) advise that it is better to use as small a number of factors as possible, but Taylor (2006) states that the large samples available means that the numbers of factors included should not be constrained; for example Hennessy (1993) used 24 dimensions in her research into factors affecting decisions about case management, resulting in 1,099,496,032,600 potential vignettes. Hennessy

argued that because a sampling approach is used, respondents rate only a subset of all possible combinations of factors, and this means that practical restrictions on numbers of dimensions are eliminated. This is one example of inconsistency in the literature about the statistical considerations of factorial surveys; additionally there does not appear to be an agreed formula to calculate sample size in factorial surveys, and there is a lack of consensus around the model of multiple regression which should be used in analysis. This is discussed in more detail later on.

It has been suggested that factorial surveys have an advantage over attitude questionnaires because they anchor a judgement in a firm situation which reduces the possibility of an unreflective reply (Bryman, 2008). Finch (1987) argued that because questions are framed in relation to a series of concrete situations concerning hypothetical third parties, they are also likely to be viewed as less threatening than studies that directly question people about their views on sensitive topics. Finch maintains that the hypothetical nature of the questions has the effect of distancing the issue from the respondent and their own experience with similar situations in real life, and this is what makes factorial surveys less threatening. However Bryman (2008) points out that respondents are still likely to realise that their responses will reflect on them, regardless of if they are about them or not. Other authors maintain that because factors are manipulated in a way that participants are probably not aware of, participants are subjected to less social desirability bias than in other forms of research (Wallander, 2009).

Because concerns have been raised about the extent to which responses to factorial surveys can be generalised (Rossi & Nock, 1982), it is important to construct credible scenarios (Bryman, 2008). Wallander (2009) adds that orthogonality of factors may

lead to unrealistic combinations in the vignettes, resulting in judgements that are not grounded in reality (although this is not always the case). Lauder (2002) asserted that “factorial surveys may offer a more accurate representation of an individual’s beliefs than could be inferred from observing how individuals respond to a real life situation” (pg. 38), because they are not constrained by situational factors which may distort the process of converting beliefs into actions. Because this study will use vignettes to measure the effects of training, this assertion is important to bear in mind; training transfer is what occurs despite situational constraints, so results of a vignette based study may not reflect participants’ real life actions. On the other hand, as discussed earlier the effects of training are well known to be mediated by organisational and workplace barriers and so vignettes may be a more accurate way of measuring the pure effect of training on knowledge and attitudes before it is influenced by other factors.

However, other authors have praised the internal and external validity of factorial surveys. Ludwick and Zeller (2001) state that internal validity is increased because the independent variables or factors presented in each vignette are randomised and orthogonal, and their values are not limited to the variance of the values in any real world situation. Because the selection of a factor to be presented in a vignette is independent of the other factors already chosen, it is possible to isolate the effect of each individual factor (Wallander, 2009). This is especially useful for unpicking the factors that affect professional decisions such as making safeguarding adults alerts where, for example, influences such as poor organisational support and a negative approach to whistleblowing are usually difficult to separate. External validity is also



highlighted as high due to the survey aspect of the design, resulting in probability sampling of large populations (ibid).

For this study, the literature on safeguarding adults, presented in Chapter 2 and 3 was reviewed in order to select the factors to include in the vignettes. A vignette framework that could be populated with orthogonal combinations of the factors while preserving the flow of the narrative was written. Care was taken to ensure that factors would not contradict each other if combined in a vignette. Due to the length of the resulting vignettes, it was decided to present each participant with 8; 2 baseline vignettes, and 6 experimental ones. Further details are outlined in section 6.3.6.

### 6.3.5 Methodological ambiguities

Although factorial survey method appears to have many merits, literature using the method is limited. A review of sociology literature that used the factorial survey method, which included papers published in core or priority sociology journals between 1982 and 2006 returned only 92 results, 18 of which were categorised as relating to family and social welfare (where child abuse was categorised) (Wallander, 2009). No papers related to safeguarding adults. An additional problem is the lack of consensus over how exactly a factorial survey study should be carried out. Some of the ambiguities resulting from a preliminary search of the literature using factorial surveys are outlined below; a summary of the studies found in the search is in Appendix I .

There does not appear to be a clear method to decide on sample size in factorial surveys. Sample sizes achieved in previous vignette studies show a large range (see Appendix I ). The number of vignettes obtained in the literature sampled ranges from 205 to 24,372, whereas the number of participants ranges from 38 to 1038.

Furthermore, the number of vignettes collected does not appear to have any relation to the number of vignettes that could potentially be generated. Wallander (2009) points out that because the unit of analysis is the vignette, the statistical power of the analysis is influenced both by the sample size, and how many vignettes each participant is asked to rate. She explains further than because most factorial survey studies require participants to rate more than one vignette, the participant sample size does not need to sample as many respondents as in general social survey research. For the purposes of this research the above information was taken to mean that the recommended sample size obtained through power calculations refers to number of vignettes obtained, not number of participants.

The number of dimensions and levels included in vignettes affects the number of vignettes that could potentially be generated, a consideration related to sample size. The number of potential vignettes is obtained by calculating the Cartesian product, i.e. multiplying the number of levels together; so for example if there were 3 dimensions with 3 levels in each vignette, there would be  $3 \times 3 \times 3 = 27$  potential vignettes. The number of potential vignettes in the literature sampled ranges from 27 (reduced from 486 using "fractional factorial design" (Schwappach & Koeck, 2004) to 1,099,496,032,600 (Hennessy, 1993). This number is not always reported. As mentioned above, the number of potential vignettes does not appear to relate to the participant sample size or the total sample of potential vignettes; Hennessy (1993) obtained a sample of just 38 people and 1057 vignettes, whereas Schwappach and Koeck sampled 1017 people and obtained 2289 vignettes. Using the general principles of power calculations it would be expected that a higher number of potential vignettes should demand a larger sample of obtained vignettes to a point, but no rationale

supporting or disputing this hypothesis is provided. Using formulae for calculating sample sizes for a multiple regression analysis seems to be the most appropriate method to calculate sample size (see section 6.3.8).

Taylor (2006) summarises the main issues encountered when analysing factorial surveys. One, as mentioned above, is the question of analysing by the vignette or the participant. A number of authors argue that because the vignettes are not independent of each other (because a number of them were completed by each participant), the assumptions of Ordinary Least Squares (OLS) regression are violated. This is because individuals are likely to have characteristics which are not measured in the survey, but that may affect their judgements, and considering their judgements to be independent of each other would ignore this, a problem termed intrarater correlation. Hennessy (1993) used error components regression, while Muller-Englemann et al (2008) proposed using a hierarchical regression model. However some authors have argued that OLS is robust enough to cope with non-independent cases (Ludwick *et al.*, 1999; O'Toole *et al.*, 1993; O'Toole *et al.*, 1999). Considering the evidence, Taylor (2006) concludes that using OLS is "perfectly satisfactory for practical purposes" (p1198) and gives a robust design. In her introduction to factorial surveys, Wallander (2009) highlights that the fact this issue has not yet been dealt with, despite it being mentioned by Rossi and Anderson as an important consideration for factorial survey researchers as early as 1982. She outlines a number of methods that various researchers have used to overcome the issue of intrarater correlation when using multiple regression, including using fixed effects models, robust standard errors, respondent level models, and not discussing it (the most common response). All 8 studies that used the "double check" method came to the conclusion that their original

(non-independent) conclusions had in fact been robust, which supports Taylor's argument that OLS is robust enough to cope with non-independence. For this study, the advice of a statistician was sought. She recommended creating and reporting a method of checking independence of cases, and advised following the previous literature in terms of use of OLS regression even though in her opinion, if cases are not independent it should not be used.

Against the above, it can be argued that an advantage to using vignettes is that they are statistically independent; after a factor is included in a scenario, it remains in the "pool" of potential factors to be chosen again rather than being taken out. Because the vignettes are generated randomly each time, there were no order effects relating to their presentation to bias results. Similarly although using Likert scales may result in vignettes being judged against each other, meaning responses are not psychologically independent, the random generation of scenarios prevents any effect of question sequencing.

Another consideration is the type of data yielded by the dependent variable(s). While many authors do not touch on this subject, a number have; Hennessy (1993) analysed her categorical data using ordered probit, while Lauder, Scott et al (2001) used categorical regression to analyse categorical and ordinal variables. Applegate et al (1996) chose logistical regression to analyse ordinal dependent variables. Taylor (2006) lists 3 types of data used as dependent variables; categorical, ordinal, and interval. The example of interval data ("e.g. the level of concern about a specific risk to client rated on a scale of nought to nine") can be questioned under a longstanding debate over the use of Likert scales as interval or ordinal data (Jamieson, 2004). Assuming that a scale of 0-9 is interval data has flaws, because it cannot be said that a rating of 4 represents

4 times as much concern as a rating of 1, but it means that more powerful statistical tools can be used in analysis.

The number of vignettes presented to participants in the sample of papers analysed varies from 1 (Applegate *et al.*, 1996) to 64 (Garrett, 1982). Applegate *et al.* (1996) argue that presenting participants with more than one vignette can lead to intra-rater judgement correlations (the problem of non-independence of cases) (Rossi & Anderson, 1982), so they only gave one vignette to each respondent. As a result, they obtained a much smaller number (205) of cases than most other studies. Regarding the interrater correlation issue, Cochran *et al.* (2003) stated that the problem was most pronounced when the number of vignettes rated by each individual is 30 or more. There is also the risk of rater fatigue when presenting large numbers of similar vignettes to participants, which can result in non-completion of surveys or unconsidered responses.

Baseline vignettes have been used in a number of studies to control for the rating tendency of participants (Garrett, 1982; Ludwick *et al.*, 1999; O'Toole *et al.*, 1993; O'Toole *et al.*, 1999). By asking participants to rate a number of vignettes that are identical, we can adjust for individual differences in rating tendency. This can help overcome problems with skewed responses (i.e. judgements mainly made at the upper end of a continuum) which have been demonstrated in studies concerning abuse (O'Toole *et al.*, 1999). Having a technique to adjust data to minimise skew is important when using multiple regression, which assumes normally distributed errors.

Average scores on baseline vignettes have also been used as covariates in the regression model (Garrett, 1982; O'Toole *et al.*, 1993; O'Toole *et al.*, 1999). Garret found that average baseline scores coupled with demographic characteristics

explained 14% of the variance. Further analysis suggested that respondents differ in their average rating tendencies according to their demographic characteristics, but agree on the principles behind rating vignettes. O'Toole et al (1993) found that average baseline scores were the 3<sup>rd</sup> best predictor of recognition and reporting of child abuse. Finally, there does not appear to be any up-to-date, easily accessible software that creates and administers factorial surveys online. This problem is identified in a paper claiming to be in the process of creating such software (Addala, Hogben & Addala, undated). The company's website (<http://www.e4xchange.com>) is last dated 2004, and emails to the contacts are bounced back or receive no response, implying their software may not have been successful. Many of the studies mentioned have been paper based, which implies costly printing and postage bills, costly data transcription and risk of transcription error. One study utilised an internet survey panel (called "Gesundheitspanel"), and (perhaps coincidentally) received one of the highest response rates noted in the current search of the literature (Schwappach & Koeck, 2004).

Hennessy, MacQueen and Seals (1995) used a computer programme, Medialab, to create a factorial survey. Although it is not internet based, it relieves researchers of the issues associated with transcription by automatically saving data to a data file. The authors commissioned Medialab programmers to create a factorial survey program for them. Hennessy clarified that programmers did not use Medialab commands to create the program (Hennessy, 2010).

The Medialab method was used in this study on recommendation; unfortunately it was only after the long and painful process of creating the factorial survey that contact was

made with Hennessy. Problems encountered with this approach in the current study include that:

- Medialab is expensive (so in this study was only available on one computer, making it difficult to achieve large sample sizes as the computer needed to go to the participants)
- Creating factorial surveys with it is problematic (if expert technological support is not available).

Creating an (affordable, e.g. open source) online factorial administration programme has the potential to increase the uptake of this method greatly. However an advantage of the face to face method used here was that the researcher could support participants through the programme, clarifying any issues and minimising non responses. A number of participants required assistance using a laptop, which the researcher could provide.

### 6.3.6 Constructing the vignettes

The vignettes were constructed using nine dimensions with different response sets ranging from 3 to 12 levels, giving a total of 17,280 potential vignettes. The dimensions that were decided on following the review of the literature (see Chapter 3) are outlined below. They fit into a written framework which is repeated, while the dimensions that 'fill the gaps' were chosen at random from the options below.

Dimension 1: Manager and colleague support: "You enjoy your work

1. as you have a supportive manager and colleagues
2. despite your unsupportive manager and colleagues"

Dimension 2: Whistleblowing support: "In the past, you have seen things that could have been done better. Your organisation has

1. listened to your concerns and acted on them

2. dismissed your concerns and branded you a troublemaker”

Dimension 3: Victim’s reason for accessing services: “Currently you are working with a person who

1. has a learning disability
2. is accessing mental health services
3. is older and lives in residential care
4. has a physical disability and uses a wheelchair
5. has both a learning disability and a physical disability”

Dimension 4: Psychology of victim: “You have worked with this person for some time, and find them

1. Negative: (difficult to engage with, as they often make up stories; rude and unappreciative of services; aggressive and unpredictable)
2. Positive (cooperative and appreciative of services; easy to get on with, with a good sense of humour; outgoing and friendly)”

Dimension 5: Nature/ Severity of abuse; 4 types of abuse, psychological, physical, financial and neglect were outlined in 3 levels of severity (mild, moderate, and severe), resulting in 12 levels; these are listed below: “You have noticed that

1. your colleague engages in humorous banter that the person seems to enjoy
2. your colleague ignores the person’s requests or responds with an irritated tone of voice, telling them they’re being difficult
3. your colleague frequently shouts insults at the person
4. your colleague can be a bit rough when physically assisting the person
5. your colleague increased the person’s medication to stop them being distressed
6. the person has slapped your colleague on occasion; your colleague slapped them back
7. the person has given your colleague the PIN number for their bank card. Your colleague regularly withdraws money for them. You believe the person has the mental capacity to make this decision
8. the person has given your colleague the PIN number for their bank card. Your colleague regularly withdraws money for them. You do not think the person has the mental capacity to make this decision



9. your colleague has persuaded person to write them into a will, leading to a substantial inheritance, to the dismay of family. You believe the person has the mental capacity to make this decision
10. the person sometimes refuses to wash or clean their teeth. Your colleague does not enforce a personal hygiene routine
11. the person has been ill because your colleague occasionally forgets to give them their medication
12. your colleague locks the person in their room for long periods without food, water or opportunity to use the toilet in order to carry out domestic tasks 'in peace'. The room is dirty and smelly"

Dimension 6: Perpetrator past behaviour:

1. "You think your colleague has behaved in this way with other people before."
2. "This is the first time you've been aware of your colleague behaving in this way."

Dimension 7: Victim perception of perpetrator: "The person has told you that

1. they don't like being supported by your colleague
2. your colleague hurt them
3. they get on really well with your colleague"

Dimension 8: Victim attitude towards information sharing

1. "The person has also asked you not to tell anyone about the situation."
2. "You and the person have agreed that you can share information about them when necessary."

Dimension 9: Your perception of perpetrator

1. "You are good friends with your colleague and believe they wouldn't have meant any harm"
2. "You and your colleague have never been very friendly"
3. "You know your colleague hasn't had any training"

An example of one possible vignette is outlined below.

You enjoy your work, despite your unsupportive manager and colleagues. In the past, you have seen things that could have been done better. Your organisation has dismissed your concerns and branded you a troublemaker. Currently you are working with a person who is older and lives in residential care. You have worked with this person for some time, and find them generally cooperative and appreciative of services. You have noticed that your colleague can be a bit rough when physically

assisting the person. You think your colleague has behaved in this way with other people before. The person has told you that your colleague hurt them. You and the person have agreed that you can share information about them when necessary. You know your colleague hasn't had any training.

Respondents were asked to provide ratings of recognition and necessity for making a safeguarding adults alert, along with indicating their confidence in their decision. A full outline of the measures taken following presentation of the vignettes is outlined in section 6.3.12.

### 6.3.7 Regression model

The survey tested an adapted version of the second iteration of the programme theory (see Figure 11) and the causal propositions that it implies, which outline that a combination of past experience, demographics, training, and situational cues lead to confidence in action, and appropriate recognising and reporting of abuse. The model was based on the results of the realist synthesis, explained more fully in section 8.2.

### 6.3.8 Sample size

As mentioned above, factorial survey research does not appear to have any explicit parameters to follow in terms of sample size. Values of an alpha level of 0.01, an anticipated effect size of 0.05 (small- medium) and a desired power level of 0.8 with 33 predictors (factors included in the vignettes- see section 6.3.6) resulted in a multiple regression sample size calculation of 708. An alternative power heuristic which is used specifically for multiple regression is outlined by Field (2009). He states that a minimum sample size of  $50+8k$ , where  $k$  is the number of predictors, should be used if testing an overall model; to test individual predictors, a minimum sample size of  $104+$

k should be used. Field recommends calculating both sample sizes and using the largest one. In this case, that would be

$50 + (8 * 33) = 314$  (assuming that “predictors” means individual, not groups of variables) or

$104 + 33 = 137$

Taylor (2006) argues that the unit of measurement should be the vignette rather than the participant, meaning large “sample sizes” should not be as difficult to achieve. The larger of the minimum sample sizes (708 vignettes) was chosen and a size of 50 participants from each training group, resulting in a total of 150 participants who would complete a total of 900 vignettes plus 300 baseline vignettes, was aimed for. Power defines how big a sample needs to be to observe a non-accidental difference. A desired statistical power level of 0.8 or greater is the convention in power calculations, as is 0.05 or lower for the alpha value, which is why they were chosen.

### 6.3.9 Sample.

176 health and social care staff and volunteers in Cornwall participated in the research, yielding a total of 1055 useable vignette responses, plus 352 responses to baseline vignettes. A census method utilising snowball data collection was used where possible, with initial contact made through an email invitation to participate via the distribution list of the Learning Training and Development Unit (LTDU) of Adult Care and Support. This list holds email addresses for approximately 500 individuals working in the health and social care sector, all of whom are able to access the training at no cost. It is an accurate list of everyone who has engaged with training; but does not include individuals who have not engaged with training, who are more difficult to contact. (The

list of individuals represents contact for organisations that the LTDU pass details of training on to: however the organisation associated with each individual is not currently recorded, so the number of organisations reached is unknown.) Respondents were asked if their colleagues would also be interested in participating. This method yielded limited numbers of participants, so further emails were sent to representatives of the Safeguarding Adults Board, who communicated the invitation to participate to their agency. To reach the private and independent sector, the researcher spoke at Provider Forum events. Invitations to participate were also included in a number of newsletters (a local arts charity, and the Adult Care and Support fortnightly newsletter). The emailing method was deemed unsuitable at the Hospital Trust due to volume of messages, so an opportunity sample at 2 induction events and in the canteen over 4 lunchtimes was obtained for this group. The complexity of the sampling strategy reflects the difficulty in involving a range of staff from a range of agencies in research, and the fact that the research had to be carried out face to face because the vignette programme was only available on the researchers' laptop.

#### 6.3.10 Sample demographics

By sector, 29% (n=51) of the sample worked in Adult Care and Support or Housing, 31% (n=54) in Health, and 40% (n=71) in the private, independent or voluntary sector. 99% (n=175) were paid staff, as opposed to volunteers. 50% of the sample were professionals, student professionals or managers (n=88); 41% were senior support workers or support workers; 5% were ancillary or administration staff; 3% worked in training. 49% were aged 46-65 and 25% were under 35. 49% had worked in health or social care for over 10 years. 15% had worked in the sector for 2 years or less. 38% had

worked in their current workplace for two years or under; 47% for 2-10 years, and 15% had worked in their current workplace for over 10 years.

17% (n=31) had attended Provider Manager training; 45% (n=80) had attended the Human Rights workshop; 32% (n=56) had completed only safeguarding core 1 training; 16% (n=29) had completed no safeguarding training at all. Qualifications were coded into levels according to the National Qualifications Framework (Ofqual, 2010). 37% of respondents had attained a level 3 qualification or under (including no qualifications); 52% a level 4-6, and 11% a level 7-8 qualification.

In terms of safeguarding experience, 43% of the sample had not had any experience of the safeguarding adults process, 24% had once, and 33% had more than once. 65% said they had never made a safeguarding adults alert; 11% said they had made one, and 23% said they had made more than one. Tables and graphs of participant demographics can be found in Appendix K

Although a measurement of organisational culture would be a valuable sample standardisation tool, there is little consensus in the literature about which factors are the most important ones to measure, or how they should be measured. Furthermore a review of available instruments concluded that of thirteen which had either been used, or had potential to be used in health settings, all had limitations in terms of scope, ease of use, or scientific properties. Additionally, the authors warned potential users of the instruments to carefully consider resources before doing so (Scott et al., 2003). For this reason no attempt at measuring organisational culture was made in this study.

### 6.3.11 Materials and data collection

The factorial survey was chosen to provide quantitative data on the impact of training on thresholds to alerting. This provided a cross sectional study of people who have attended varying levels of training, with responses to vignettes as the outcome measure. Searching for published training evaluations using the factorial survey method has yielded no results. However using factorial surveys has been suggested for use in pre- post-test training evaluations, and to study the threshold at which a safeguarding adults referral is made (Taylor, 2006). The researcher made every effort to facilitate engagement with the study, by adopting a range of sampling strategies, meeting participants in their workplace at a time that suited them, fully explaining the purpose of the study, and offering entry into a prize draw for vouchers of their choice as an incentive to participate. All participants completed the same 2 baseline vignettes to start with, to give a comparison of average rating tendency (O'Toole *et al.*, 1999). 6 further randomly generated vignettes were then undertaken.

Participants were presented with an information sheet, which was also verbally explained to them, and gave their informed consent to participating. A prize draw was offered to those participants who wished to enter it.

A programme of vignettes constructed using the programs Excel and Medialab was presented to participants on a laptop. The vignettes were presented in large, black font on a yellow background to facilitate accessibility. A mouse and keyboard were used to navigate through the program, and the researcher was on hand to assist with the IT. A number of participants had not used a laptop before and required support using the programme. Data was collected automatically by the Medialab program,

which wrote responses into an excel file. Data from individual files was then combined into one spreadsheet and transferred to SPSS for analysis.

### 6.3.12 Measures

Following the presentation of a vignette (scenario) using the factorials survey method, participants were asked to provide:

- Ratings of recognition of abuse on a 9 point scale (O'Toole et al, 1999), from 1- "Definitely not abuse" to 9- "Probably is abuse". A midway anchor of 5- "Might be abuse" was also used. Discussion with practitioners in the development stage led to "probably" being the most definitive rating, as a scenario would not give enough information to definitely state that abuse was occurring.
- Ratings of whether person would make a safeguarding adults alert on a 9 point scale, from 1 "Definitely wouldn't make an alert" to 9 "Definitely would make an alert". A midway anchor of 5- "Might make an alert" was also used.
- Ratings of confidence in their judgement on a 7 point rating scale, from 1 "Not confident at all" to 7 "Extremely confident". A midway anchor of 4 "Confident" was also used.

They were also asked to tick any other actions they would take as well as, or instead of, making an alert: options were:

No action needed; Wait to see if it happens again; Document the situation in case file or notes; Talk to the person; Talk to your colleague; Talk to a colleague not involved in the situation; Talk to another professional, e.g. doctor or social worker; Talk to your manager; Call 999

Previous authors (Richardson et al, 2002) have used vignettes to elicit qualitative data around responses to potential safeguarding situations, but in this case it was decided to only collect quantitative data following a pilot study, which showed that using qualitative data (e.g. responses to questions such as "why did you decide to make an

alert in this situation”) was problematic in the context of comparing groups. Problems with using qualitative data included:

- It was unclear how much effect factors such as literacy and familiarity with technology/ typing etc. have on the responses, which were typed into the program on a laptop. Answers which were not as in depth could not therefore be assumed to result from lack of knowledge or understanding.
- Typing answers was one of the most time consuming aspects of the process, and by omitting the qualitative element each participant can be asked to do more vignettes
- An initial analysis of the typed qualitative data in the pilot study did not show any marked differences between responses of those who had attended different levels of training, and due to literacy issues mentioned above it was difficult to set any sort of criteria for a “good” or “bad” answer.

### 6.3.13 Data Analysis

The research question was addressed by using an entry method in the regression, with order of variables based on preliminary analysis of the variance that each variable covers. Variables were broken into the categories of scenario, (the content of the vignette), demographics (covering sector, job role, length of service etc.), past experience of safeguarding (whether the participant has made an alert or participated in an investigation before) and training (measuring the level of safeguarding adults training they have attended). The significance criterion for the value of R was declared at 0.25.

The categorical variable (what actions they would take as well as or instead of making an alert) was analysed using correlation and chi square.

### 6.3.14 Creating a variable for difficulty of making alert.

In order to analyse the effect of training and other variables on the response to the vignette as a whole, a separate variable of “scenario difficulty rating” was created by



consensus. The researcher and one of Cornwall's Safeguarding Adults Unit's Independent Chairs independently rated how hard it would be to make an alert, considering each factor contained in the vignettes independently. The Chair was also asked to detail what impact attending training should have on making an alert in the stated circumstances. A rating of low, medium or high difficulty, or not applicable, was assigned to each of the 33 factors. Agreement was initially obtained on 27/33 items (82%). Both raters agreed that the factor "reason for accessing services" was not applicable (it would be no harder to make an alert about e.g. a person with a learning disability than an older person), but all other factors were rated. A consensus method was used to resolve differences in rating, where the two raters met to discuss and resolve differences in opinion. Consensus was reached, and the low/ medium/ high ratings were converted to a numerical scale (low=1, medium=2, high=3) and applied to the vignettes that participants had rated. Rating values varied from 8-19 and a histogram showed that they were normally distributed. The scale was adjusted to start at 1 for analysis purposes. Examples of vignettes with the lowest and highest difficulty rating are shown in Appendix J .

The Chair's views were that trained staff ought to question every scenario more closely, and be more likely to make a safeguarding alert at a lower threshold.

#### **6.4 Qualitative analysis of factors impacting on the effectiveness of training**

Data from semi structured interviews were used to address research questions 2b, 2c and 3.

**Research Question 2:** What effect do the Human Rights workshop and Provider Managers' workshop have on delegates' practice, in terms of

b) actions undertaken in the workplace as a consequence of attendance on the workshop

2c) Considering the findings of a) and b), does the Manager's training add anything (in terms of actions taken or thresholds to recognising and reporting abuse) to the effect of Human Rights workshop?

**Research Question 3:** What factors in the workshops or workplace act as facilitators of or barriers to the transfer of learning from the workshop into practice?

Version 2 of the programme theory of safeguarding adults training, illustrated in Figure 10, was used to structure the findings. Findings of the empirical research were then used to inform a final iteration of the programme theory of safeguarding adults training. While the factorial survey provides an account of the impact of training in a hypothetical way, devoid of context, the qualitative analysis explores the contextual influences of workplace and training design and delivery that impact on the effectiveness of training.

#### 6.4.1 Design

Cross sectional narrative analysis was used to provide flexibility to explore any emerging issues when discussing safeguarding adults training transfer (Taylor, 2003). Semi structured interviews were chosen because the researcher wanted to cover a clear set of topics, while giving participants the opportunity to express their views and introduce content that the researcher might not have thought to ask about (Bryman, 2008). The method was preferred over unstructured interviews to allow comparison between interviewees, and to retain some focus on the issues that the researcher

wanted to cover. It also facilitates retroductive analysis, which involves iterative analysis moving between the data and theory (see section 6.4.6).

#### 6.4.2 The use of qualitative interviews

Qualitative interviews have been used as a method of choice to investigate staff knowledge of issues surrounding safeguarding adults (Furness, 2006; Manthorpe *et al.*, 2009a; Manthorpe *et al.*, 2009b; Parley, 2010; Taylor, 2003), and safeguarding adults related topics generally (Rees & Manthorpe, 2009) as they enable access to rich and detailed data. As well as interviewing staff, some authors have recognised the potential in interviewing training providers on the subject of training transfer as a way to address “the oft-cited research-practice gap” (2009, :70). Burke and Collins (2005) interviewed training providers and former delegates to find out how to optimise the effectiveness of leadership development programmes, while Burke and Hutchins (2008) found that trainers identified supervisory support, transfer measurement, and job relevant training as best practice transfer interventions.

Triangulating the views of delegates and trainers does not appear to have been used in the literature as a means of evaluating the impact of training, but was used for this study in order to a) seek the views of trainers about how they feel safeguarding adults training is best provided, and which factors in training or the workplace facilitate transfer, and b) corroborate (or not) the findings from interviews with delegates in terms of use of preparation work, reaction to the training, actions taken, and barriers/facilitators to implementing training.

### 6.4.3 Constructing the interview guides

Three separate interview guides were created for the three groups of interviewees. Questions were designed around specific elements of the training, such as preparation for both workshops, and the Provider Manager workshop's one and a half day structure, and also sought to uncover any factors in the workshop or workplace that helped or hindered the transfer of safeguarding adults learning to practice. The interview guide was based on the one used by Stolee et al (2009). All three guides also included questions on the advantages and disadvantages of multiagency training, and asked about the impact that the programmes had had on delegates practice.

The Provider Manager interviews included a question about how interviewees as managers supported their staff to transfer learning into practice. The trainers' interview questions acted in part as a way to verify the generalisability of the interview participants' responses, by asking, for example, questions about the number of people who completed the preparation work before attending both sessions. This aimed to reduce the sampling bias present in a self-selecting sample, where it can be argued that delegates who wish to participate are more engaged with and interested in training than the general population.

The interview guides can be found in Appendix L and M.

### 6.4.4 Sample

Ten delegates from both the Human Rights and Provider Manager workshops, and three trainers who facilitate both sessions, were interviewed.

For Provider Manager attendees, an attempt was made to recruit numbers of participants from each sector proportionate to the numbers who have attended the

training. 10% of attendees came from an NHS setting, 24% from Adult Care and Support, and 67% from the independent sector, so the study aimed to recruit one person from the NHS, two from Adult Care and Support and seven from the independent sector. Provider Manager delegates were sampled by randomly choosing people, using random number generating software, from the Learning Training and Development Unit's list of attendees, and emailing them to ask if they would like to participate. If no response was received, a second email was sent. 20 people were contacted using this method, which led to four participants agreeing to take part. The other 16 either did not respond or replied that they did not have the time to participate. One participant expressed an interest in participating to the researcher at a training event that they both attended.

Due to the time-intensive nature of randomly selecting and emailing participants, it was decided to change the strategy to sending out an email to the whole LTDU distribution list to request participants. This yielded four further participants. The final person was recruited by emailing NHS staff to request their participation, as none had yet been recruited. After three refusals on the grounds of time or work pressures, one person was recruited.

The final sample comprised two people from Adult Care and Support, one from the Primary Care Trust, three from charities and four from the independent sector (two domiciliary, one housing and one residential). Six participants had made a safeguarding adults alert before; four had not. Seven had been involved in a safeguarding adults investigation before; three had not. Four people had attended the workshop over six months previous to the interview; two had attended 4-6 months previous; and four had attended less than three months ago. They held a variety of managerial and

professional roles. Three people had worked in health or social care for over 25 years, two for over 20 years, two for over 15 years, one for over 10 years, one for over 5 years and one for under 5 years. Nine participants were female and one was male. The sample was representative of the agency mix that had attended the workshop.

A similar method was used to recruit human rights attendees. Proportionately, 23% of attendees on the Human Rights workshop were from the NHS, 28% from Adult Care and Support, 45% from the independent sector and 4% from “other” which included housing, higher education and the police, leading to an aim of recruiting two NHS staff, two Adult Care and Support staff and six independent/ other staff. Delegates chosen using a random number generator were emailed to ask if they would like to participate. However, 13 requests led to five refusals due to time/ work pressures, and eight non-responses. Following an email to the LTDU distribution list, six participants were recruited, none from the NHS. Contacts working in the training units of NHS Trusts were emailed, to request help with recruiting participants; this led to three recruits from one NHS trust. The final person was a member of homecare staff, recruited though a personal contact.

The final sample consisted of two people from Adult Care and Support, three people from Cornwall Partnership NHS (Mental health) Trust (one who also worked in an independent residential home), two people who worked in charities, two from independent residential homes, and one from independent domiciliary care. Eight participants had not made a safeguarding adults alert before; two had. Four had been involved in a safeguarding adults investigation before; six had not. Three people had attended the workshop over 6 months previous to the interview; two had attended 4-6 months previous; and five had attended less than four months ago. Four people held a

professional or student professional post; three were managers or deputy managers; and three held a support worker role. Two people had worked in health or social care for over 25 years, one for over 15 years, one for over 10 years, two for over five years and four for fewer than five years. Nine participants were female and one was male. The Human Rights workshop is considered mandatory for all levels of staff, but it is worth noting that 7 of 10 participants held a senior role.

Tables and graphs of participant demographics can be found in Appendix O

Three trainers were selected for recruitment on the basis of having facilitated both the Provider Manager and Human Rights workshops, and therefore meeting the sampling requirements. Two worked for Adult Care and Support, and one worked at the NHS Hospital trust. All three had previous experience of working as a practitioner in health or social care.

#### 6.4.5 Procedure

People who expressed an interest in participating were emailed an information sheet and an outline of the questions, and asked for a range of dates that would be suitable for interview. Participants were interviewed face to face, on their own, at a location and time of their choice. One researcher conducted all 23 interviews; at the beginning of the interview she explained that she had a stammer and used a breathing technique to control it, and this was responded to positively by participants. 2 of the Human Rights interviewees, 5 of the Provider Manager interviewees and all 3 of the trainers had met the researcher before due to contact through work. This meant they had a variable understanding of her interest in training transfer; some of them had attended presentations she had given talking about training effectiveness. This may have led to

participants responding to demand characteristics, but unfortunately due to low response rates, excluding respondents known to the researcher was impractical. To try and minimise demand characteristics, confidentiality was assured and it was emphasised that there were no right or wrong answers as the research was exploratory.

At the interview, each participant was presented with the information sheet and an informed consent form (see Appendix P ), which outlined the right to withdraw, the voluntary nature of participation, and anonymity with the caveat of if they disclosed that they or someone else may be in danger of harm, the researcher would either inform the appropriate authority or assist them to do so. Interviews were digitally recorded and took between half an hour (human rights) and almost 2 hours (trainer). Some interviews were subject to interruption (e.g. phone calls, colleagues needing to speak to participant); during this time the recording was stopped and restarted afterwards.

#### 6.4.6 Analysis

Previous studies using interviews to find out about staff knowledge around abuse have either included little (Manthorpe *et al.*, 2009b; Parley, 2010) or no (Furness, 2006; Taylor, 2003) information about how the data were analysed. A later study by Manthorpe *et al* (2009a) gives further details of data analysis by referring to a paper by Braun and Clarke (2006) which gives a useful guide to the epistemological and methodological questions that researchers should address when analysing qualitative data. That framework was used here. Broadly, a thematic analysis method was used; this is defined as



“a method for identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail. However, it often goes further than this and interprets various aspects of the research topic.” (Braun & Clarke, 2006, :7)

Braun and Clarke state that poor definition of the method of qualitative analysis may present a challenge to evaluating research or synthesising it with other findings. They elaborate,

“what is important is that the theoretical framework and methods match what the researcher wants to know, and that they acknowledge these decisions and recognise them as decisions” (ibid: 9).

A realist approach was used here, where the experiences, meanings and reality of participants was reported. The realist perspective assumes that it is possible to objectively define the structures and processes that influence the actions of people, in order to identify the causal mechanisms that are at work. This perspective was used because it has synergy with the realist synthesis approach used in this study. A simple and largely unidirectional relationship between experience and meaning and language was assumed (Braun & Clarke, 2006).

Retroduction was considered appropriate to use with the realist approach. Blaike (2010) states that the aim of retroductive research is to “discover underlying mechanisms that, in particular contexts, explain observed regularities” (pg. 87), and it does this through working back from the data to a possible explanation. The regularity to be explained is described, and then the characteristics of the context and contending mechanisms are examined. The relevance of the mechanism is then investigated, and the features of the context that either support or prevent the

mechanism from working are discussed. Figure 6 shows the explanatory model (Pawson & Tilley, 1997). In this case the regularity is training transfer, and the outcome is improved safeguarding. The mechanisms consist of aspects of the training, workplace and individual characteristics, and the context is health and social care and delegates' workplaces. The retroductive approach fits well with realist synthesis.

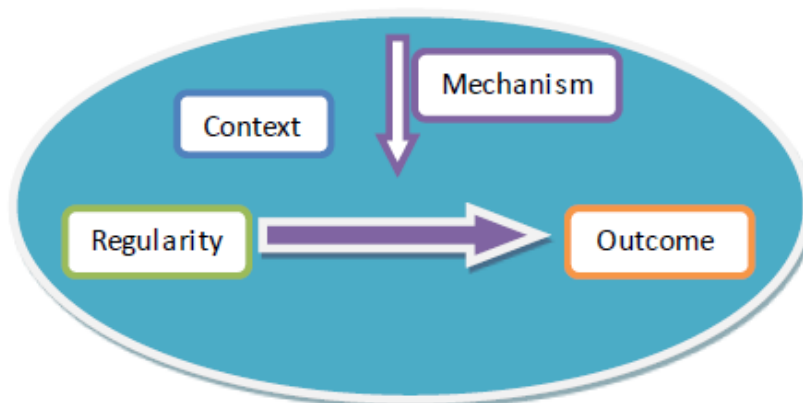


Figure 6: Diagram showing the effect of a mechanism in a particular context (adapted from Pawson and Tilley, 1997)

Blaikie states that the central problem for the retroductive approach is “how to discover the structures and mechanisms that are proposed to explain observed regularities” (Blaikie, 2010, :87), but this problem was addressed by examination of the policy and the literature for the programme theory relating to safeguarding adults training. An iterative approach was used here, where the data was mapped onto the revised version of the safeguarding adults training programme theories originally extracted from policy and back again.

A semantic approach was used because this, again, corresponds to a realist paradigm. Themes are identified within the explicit or surface meaning of the data, leaving less scope for bias or researcher interpretation of underlying meaning. This is important in this case, as the researcher was involved in designing the training programmes. The

process of analysis progresses from description, which organises and summarises patterns of data, to interpretation, where broader patterns and their meanings and implications are theorised with references to the existing literature, and in this case, programme theories, and back again using an iterative process.

#### 6.4.7 Process of analysing

A six step approach outlined by Braun and Clarke (2006) was used to initially analyse the data. This entailed becoming familiar with the data (this included transcribing it) before generating initial codes, which involved reading through transcripts and coding each segment of data that may be of interest later. As recommended by the authors, the data was coded for as many patterns as possible. Themes were then generated by grouping codes together; themes were then reviewed and refined. Braun and Clarke state that that “data within themes should cohere together meaningfully, while there should be clear and identifiable distinctions between themes” (page 20). The themes were then named and defined, and a report was produced for each of the set of three interviews. This was done to ensure clarity over the contribution of each perspective. These three reports were then synthesised into one chapter, which tackles the research question of impact of each course, facilitators and barriers of transfer, and the merit of having a Provider Manager level of training. The chapter is structured around the second iteration of the programme theory expressed in Figure 10.

### 6.5 **Synthesising the findings from all 3 methods.**

A realist synthesis approach was used to synthesise the results from the literature review, factorial survey and semi structured interviews. Findings from all methods

were used to successively test pre-defined programme theories about the mechanism of action through which safeguarding adults training transfer occurs.

Causal propositions generated from the second version of the programme theory were compared to the data collected in the factorial survey and the qualitative analysis. Each part of the model was either retained or revised depending on the fit of the data with the model. Factorial survey data gave insight into the individual psychology of the impact of training, whereas the qualitative analysis illuminated the contextual considerations. Following this process, a third and final iteration of the programme theory was produced.

## **6.6 Ethics**

Ethical approval was obtained from the NHS South West Research Ethics Committee (REC reference number 10/H0203/51), the University of Plymouth, and Cornwall Council. Confidentiality in the context of the possibility that a participant might disclose a safeguarding situation during the course of interviews was discussed.

It was acknowledged that bad practice does exist, and anonymity may encourage openness and honesty around poor safeguarding adults training transfer. The duty of the researcher to report abuse or bad practice should she uncover any was also considered. It was decided that anonymity would be assured to participants, with the caveat that should they disclose that they or someone else were in danger of harm, the researcher would notify the appropriate authority or support them to do so. An Independent Chair of the Safeguarding Adults Unit agreed to act as an advisor should any such disclosure be made during the factorial surveys or interviews. No disclosures

were made during the completion of either part of the research. Ethics related documentation can be found in Appendix P .

## **Chapter 7 Training transfer research: a systematic literature review with realist synthesis.**

### **7.1 Introduction**

This chapter details the findings of the systematic literature review, which updated the review conducted by Burke and Hutchins (Burke & Hutchins, 2007). The aim of the review was to find out what factors influence training transfer generally. The review supported the notion of Baldwin and Ford (Baldwin & Ford, 1988)'s model of transfer, and identified a number of factors which may be worthy of further investigation.

### **7.2 Preface to the literature review**

Training transfer is defined as “the use of training knowledge and skill back on the job” (Burke & Hutchins, 2007, :265). Literature addressing the topic is generally divided into three categories, based on a taxonomy outlined in Baldwin and Ford (1988)'s seminal paper, which defined trainee characteristics, training design, and the work environment as the training inputs. This taxonomy was used to structure Burke and Hutchins' review, and a similar framework will be used here. Under each factor heading, a brief summary of their findings will precede findings of this review, followed by a summary of any changes in the evidence base that have been uncovered in the 5 years since their review was carried out.

### **7.3 Paper characteristics**

Papers were all written in English, but featured studies that had been carried out in a range of countries. The majority of the literature came from the USA (37 papers), followed by 9 from the UK, 8 Canadian, 7 Australian and 6 German papers. There were 2 papers each originating from Belgium, Netherlands, Portugal and Taiwan. A single

paper was included from Bhutan, Brazil, Cambodia, China, Denmark, Greece, Israel, Korea, Nepal, New Zealand, Pakistan, Saudi Arabia, Spain and Thailand. One Australian cross cultural study looked at differences between Kenya and Australia. While the international nature of the literature is advantageous in that it infers the universality of the training transfer problem, it should be recognised that interpretations of language may be different across countries and cultures (particularly in cross cultural studies), which could contribute to explanation of the findings. Furthermore attitudes to learning, training and evaluation may be culture specific; none of the studies focussed on these questions.

Table 6 shows the number of different types of research design included in the review.

<b>Research design</b>	<b>No.</b>
Questionnaire or survey	51
Non-RCT experimental/ quasi experimental study	15
Mixed methods	7
Qualitative	7
Meta-analysis	5
Case study	2
RCT	2
Ethnographic study	1
<b>Total</b>	<b>90</b>

**Table 6: Number of each research design included in the systematic literature review**

The high number of questionnaire/ survey papers emphasises the need to check for same source/ same measurement context bias. The relatively low number of experimental studies, and only two randomised controlled trials, may reflect the difficulty of carrying out controlled research in the field; some papers discussed the constraints on their research imposed or encountered through conducting field

research (Green & Skinner, 2005; Murthy et al., 2008). 83 papers were field based, compared to 2 lab studies and 5 metaanalyses.

<b>Job type</b>	<b>No of papers</b>
Many job types	27
Managers	11
Teachers	6
Banking staff	5
(N/A- Metaanalysis)	5
Call centre	4
No info	3
Nurses	3
Students	3
Trainers	3
Academic staff	2
Mental health practitioners	2
Office professionals	2
Care	1
Community counsellors	1
Engineers	1
Industrial safety inspectors	1
Nurses and managers	1
Nursing assistants	1
Paper production	1
Publicsector	1
Publicwelfare workers	1
Research assistants	1
Residents and faculty	1
Technical operational	1
Volunteer supervisors	1
Youth leaders	1
Total	90

Table 7: Job type of participants from papers included in the systematic literature review



Concerning participants, 24 papers used under 50 participants, 73 papers used under 300 and 7 papers included over 500 participants, with the highest number being 3250. Of the 51 papers that gave response rates, 36 were over 50%. 77 papers used employees as participants; 3 used training providers, and 2, undergraduates. The remaining papers used adult learners, employees and training providers, and postgraduate students on a training course. Table 7 shows the type of job participants had.

32 papers conducted their research in a single organisation. 18 used 2-100 organisations, and 1 used over 100. 25 implied “many” organisations had been included but did not provide a number; 9 gave no information.

#### **7.4 Measures of transfer.**

Most studies used self-reports of transfer. Some studies used one or more validated scales to measure generic training transfer; these included Xiao (1996)’s training transfer scale, Facticeau, Dobbins et al (1995)’s transfer scale, Gist, Stevens et al (1991)’s scale of maintenance or Tesluk, Farr et al (1995)’s scale of generalisation (Chiaburu & Lindsay, 2008; Chiaburu, Van Dam & Hutchins, 2010; Chiaburu, 2010; Chiaburu & Tekleab, 2005; Devos et al., 2007; Scaduto, Lindsay & Chiaburu, 2008; Switzer, Nagy & Mullins, 2005; Velada et al., 2007). Other studies used the Training Performance Transfer scale (Petty, Lim & Zulauf, 2007), or measured constructs such as transfer motivation, motivation to learn or transfer intention using validated scales (Al-Eisa, Furayyan & Alhemoud, 2009; Egan, 2008; Rogers & Spitzmueller, 2009; Rowold, 2007b; Smith et al., 2008; Tai, 2006; Van den Bossche, Segers & Jansen, 2010).

The majority of studies aimed to measure subject specific transfer, and so had to create their own measures. The degree of rigor involved in describing the piloting and checking of reliability and validity of the scales was variable, and methods included percentage scales asking how much had been transferred (Lee, 2010) qualitative data (Meyer et al., 2007) and a question asking “did you transfer fully, partly or not at all?” (Sofo, 2007). Other studies used established methods to create subject specific measures (Pattni & Soutar, 2009; Pattni, Soutar & Klobas, 2007). One qualitative study found that although teachers maintained that continuing training resulted in the constant transfer of learning, they were unable to give any specific examples or state the frequency of transfer, leading the researchers to question whether transfer was actually occurring (Pineda-Herrero et al., 2010). Other studies asked delegates what they perceived as important in affecting transfer (Nikandrou, Brinia & Bereri, 2009). It appears there is no clear consensus yet about how to best measure transfer, and indeed it may vary according to the type of training being evaluated.

Another method used was to measure behaviour through reports of others and this, again, was achieved using a variety of means. These included Behaviour Observation Scales (Brown & Warren, 2009), expert rating of role played behaviour (Cole, 2008; Heaven, Clegg & Maguire, 2006; Rowold, 2007b), and 360 degree feedback (Ladyshevsky, 2007). Supervisor ratings of transfer have been used in a number of studies (Lyons, 2008; Martin, 2010; Pattni, Soutar & Klobas, 2007). Supervisor ratings have a number of advantages, including performance objectivity, but can also suffer from measurement error, bias, or demand characteristics. Some measures made attempts to ascertain whether organisational goals had been attained through

training; for example monitoring of call accuracy or duration following call centre training (Murthy *et al.*, 2008), and sales performance data (Liebermann & Hoffmann, 2008; Lyons, 2008).

Studies that triangulated measures of trainees and managers were limited. Some showed interesting disparities in ratings; in one study, supervisors thought that their support positively influenced motivation to transfer, whereas delegates thought the opposite (Nijman *et al.*, 2006). Others demonstrated agreement between supervisor and delegate ratings of transfer; ratings were significantly correlated, and not significantly different (Park & Wentling, 2007). A further example used cross sectional questionnaires to measure personality variables near the beginning of the programme, test scores at the end and supervisor assessment of performance (Tziner *et al.*, 2007).

In a small sample qualitative study following up 2 years after successful teacher training, Stes, Clement *et al* (2007) found there was no clear link between self-reports of individual and institutional change. Blume *et al* (2010) found that a longer time lag between training and measuring transfer led to a smaller relationship.

Trainers have also been used to rate the impact of training (Rowold, 2007a). A study by Saks and Belcourt (2006) asked 1300 training professionals to estimate the proportion of learning transferred to practice following their programmes. The 150 respondents estimated that an average of 62%, 44%, and 34% of employees transfer immediately, 6 months, and 1 year after training respectively. The authors concluded that not enough pre and post training interventions were being utilised by training professionals, meaning that organisations were not getting the most out of their training programmes.

One study compared the effect sizes for ratings of the transfer of management training obtained from peers, subordinates, supervisors and self (Taylor, Russ-Eft & Taylor, 2009). In an attempt to ascertain whether the source of rating had an impact on the degree of transfer reported, a meta-analytic approach including 107 papers where a post-test measure and experimental/ control group design was used. Size of effect was largest when self-rating was used, followed by superior and peer ratings; subordinates gave the lowest transfer ratings. These findings were supported by Blume et al (2010), who also found a moderate correlation between self and “other” ratings both when “others” were supervisors or peers. Furthermore, using raters who were blind to the condition resulted in smaller effect sizes. Criterion measures related to training objectives gave higher transfer estimates than those related to job performance (Taylor, Russ-Eft & Taylor, 2009).

The following sections outline the three groups of factors, learner characteristics, intervention design and delivery, and work environment factors. An outline of the evidence about each variable is followed by a summary of the variables in that category.

## **7.5 Learner characteristics**

### **7.5.1 Cognitive ability**

Although Burke and Hutchins (2007) outline clear support for a link between general mental ability and transfer, the subject was only broached by two studies included in the current review. Although cognitive ability cannot be manipulated in employees, it is a characteristic that employers can recruit for. The small number of studies on this topic may reflect the fact that many lower paid or ‘unskilled’ jobs do not recruit along

this dimension. One study that included general mental ability as a control variable found that it had a significant negative predictive effect on post-training performance (Tews & Tracey, 2008), a finding opposed to previous research. More reliable may be Blume et al's finding that cognitive ability had a moderate relationship with transfer (Blume *et al.*, 2010).

### 7.5.2 Self-efficacy

Self-efficacy is “an individual's belief that they can successfully perform a task” (Chiaburu & Lindsay, 2008, :200) and has had strong support for its role in transfer (Burke & Hutchins, 2007). Recent literature has found that self-efficacy is positively related to supervisor and perceived organisational support (Chiaburu, Van Dam & Hutchins, 2010), utility reactions and learning (Tai, 2006), and training transfer (Devos *et al.*, 2007; Velada *et al.*, 2007). The terms self-efficacy and confidence have been used interchangeably (Combs & Luthans, 2007). Lack of confidence in skills has been cited as a barrier to transfer (Gauntlett, 2005). Kennedy-Merrick, Haarhoff et al (2008) found that confidence was related to training transfer of a cognitive behavioural therapy programme, and suggested that working on self-efficacy may benefit transfer. Gauntlett found that opportunity to practice skills was important in increasing confidence.

However other studies have failed to find a direct link between self-efficacy and transfer and suggested instead that self-efficacy impacts on motivation to learn, which then affects performance (Chiaburu & Lindsay, 2008; Tziner *et al.*, 2007). Other studies have reported a positive relationship between self-efficacy and transfer motivation (Al-Eisa, Furayyan & Alhemoud, 2009; Tai, 2006), again raising the possibility that the

effect of self-efficacy is moderated by other transfer antecedents, such as motivation. Al-Eisa et al found that confidence in ability was not enough to master the content of training; motivation to learn and supervisor support were better predictors of the outcome variables than self-efficacy.

Self-efficacy may therefore affect transfer either directly, or indirectly, depending on the programme and other situational characteristics. Furthermore, self-efficacy has been shown to be important both to individual and to team performance (Chen, Thomas & Wallace, 2005).

Training mode related self-efficacy may also be important. "Computer confidence" was found to account for a large proportion of e-learning transfer variance in a study by Park and Wentling (2007), leading the authors to recommend a pre-training intervention to up skill potential e-learning users in IT if necessary.

Other studied training programmes have aimed to increase domain specific self-efficacy. A programme focussed on increasing diversity self-efficacy found that it fully mediated the relationship between training and intended actions. The relationship continued at 1 year follow up (Combs & Luthans, 2007). Other studies have found that active learning is positively related to teacher efficacy (Ingvarson, Meiers & Beavis, 2005); self-management training- which helps people develop the skills to engage in self-regulating behaviour to overcome challenging situations- improves work related self-efficacy (Pattni & Soutar, 2009; Pattni, Soutar & Klobas, 2007); a negotiation skills programme that utilised role play as an opportunity to practice skills increased confidence in negotiation skills (Taylor, Mesmer-Magnus & Burns, 2008).

It appears that irrespective of the mechanism by which it works, training that focuses on developing domain specific self-efficacy will have the most effective course outcomes (Combs & Luthans, 2007). Opportunity to practice skills, actively engaging in learning and self-management techniques may also be important in developing self-efficacy.

### 7.5.3 Motivation

Numerous motivation related constructs have been addressed in the literature.

Motivation to transfer is “the desire of a trainee to use and apply knowledge and skills developed in training... to relevant work situations” (Egan, 2008, :301). Burke and Hutchins noted that most work concerns the antecedents of motivation to transfer, and called for further research into the relationship between motivation to transfer and transfer. A positive link to transfer has since been supported (Devos *et al.*, 2007; Liebermann & Hoffmann, 2008). Further work on the antecedents of motivation to transfer has found an influence of organisational subculture (which was greater than the influence of organisational culture) (Egan, 2008), an improved transfer climate (Nijman *et al.*, 2006) and helpfulness of performance feedback (Van den Bossche, Segers & Jansen, 2010).

A similar concept, motivation to apply learning, was found to be a significant predictor of training effectiveness and the type of training (high or low complexity) also impacted on the relationship (Pilati & Borges-Andrade, 2008).

The investigation into extrinsic and intrinsic components of motivation to transfer has been continued by Gegenfurtner *et al* (2009). Autonomous (intrinsic) motivation to

transfer is “is initiated and governed by the self (i.e. regulated... by integration with one’s values” whereas controlled (extrinsic) transfer is “a desire to transfer learning that is... regulated by external rewards or sanctions” (ibid: 126). Burke and Hutchins reported intrinsic motivation appeared to have more impact on transfer, though extrinsic motivation was also important in some cases. Gegenfurtner, Festner et al (2009) found that autonomous motivation to transfer was predicted by attitudes, relatedness (the extent that delegates felt respected and connected to their organisations), and instructional satisfaction whereas controlled motivation to transfer was predicted by attitudes towards the training content.

Motivation to attend may also be an important factor in transfer (Taylor, Ayala & Pinsent-Johnson, 2009). Green and Skinner (2005) found that delegates who attended a time management course through their own volition, or to achieve a clear aim (i.e. avoiding redundancy) had the largest mean gain in improvement. Voluntary participation was found to have a moderate correlation with transfer in Blume et al’s metaanalysis (Blume *et al.*, 2010).

Motivation to learn, which was only briefly mentioned by Burke and Hutchins, has received increased attention in recent years. Metaanalyses of learning transfer interventions found that increasing motivation to learn had a significant impact on performance (Leimbach, 2010) and transfer (Blume *et al.*, 2010), while another study found it impacted on both learning and performance (Tziner *et al.*, 2007). Pilati and Borges-Andrade (2008) found that motivation to learn, measured before training, affects the effectiveness of training long after completion (though other factors in their model, such as motivation to apply, had higher predictive power). Motivation to learn



has also been found to positively predict transfer antecedents including transfer motivation (Rowold, 2007b) and transfer intention (Al-Eisa, Furayyan & Alhemoud, 2009).

Other authors have studied the dimension of training motivation, described by Burke and Hutchins (2007) as the “intensity and persistence of efforts that trainees apply in learning-orientated improvement activities before, during and after training” (p627). In a cross sectional study, Scudato, Lindsay et al (2008) found that training motivation positively predicted training transfer, generalisation and maintenance; however Chiaburu and Tekleab (2005) found that training motivation only predicted training maintenance, and not declarative knowledge, training transfer or training generalisation. The two studies used the same validated scales for all dimensions, but in different contexts; this implies that another factor may moderate the relationship between training motivation and transfer outcomes, perhaps something in the workplace. The predictors of training motivation were identified as education, continuous learning culture (until supervisor support as added to the model) and supervisor support (Chiaburu & Tekleab, 2005). In an extension of work by Facticeau (1995) pre-training motivation was investigated by Switzer, Nagy et al (2005), who found that it was affected by self-efficacy, reputation of the training programme, and managerial support. Pre-training motivation was also correlated with transfer.

One study investigated goal intentions as an alternative way to understand motivation in training (Smith *et al.*, 2008). Goal intentions, defined as “decisions that transform a desire into a goal” (pg. 56), were found to be predicted by proximal factors including self-efficacy, expectancy and valence. Goal intentions

significantly predicted affective reaction, perceived utility, and intention to transfer; the authors concluded it could be used as a suitable alternative measure of motivation in transfer research, and should be researched further. They also suggested that mandatory training programmes should incorporate more pre training work to increase motivation before attending (Smith *et al.*, 2008).

Taken together, the findings suggest that increasing motivation to attend, learn, and transfer/ apply before attending will benefit transfer. Pilati and Borges-Andrade (2008) suggest preparing learners for training would achieve this. Proximal factors (e.g. organisational subculture, managerial support, and self-efficacy) may have more impact on motivation than distal factors. The literature would benefit from defining the relationship between the numerous motivation related constructs (e.g. does “training motivation” encompass the others or it is a separate entity?).

#### 7.5.4 Personality

Burke and Hutchins dedicate substantial space to a discussion of the impact of personality on transfer. Like cognitive ability, this is an innate and hence unchangeable characteristic which again may explain a drop in interest in recent years- although, as with cognitive ability organisations could select for particular personality characteristics if appropriate. A study of public welfare workers in the USA found that people who scored higher in extraversion, and lower in neuroticism, rated higher transfer (Sullivan *et al.*, 2009). Another study found that conscientiousness had a positive impact on test grade, but not performance assessment (Tziner *et al.*, 2007), and a metaanalysis by Blume, Ford *et al* (2010) found a moderate relationship between conscientiousness and transfer, and a small to moderate relationship between

neuroticism and transfer. However other studies which included Big 5 personality dimensions as control variables found no effect (Tews & Tracey, 2008).

The effect of personality on transfer antecedents, such as motivation, has also been investigated. Extraversion had a direct influence on motivation to learn, and transfer motivation, in a longitudinal study of call centre staff in Germany (Rowold, 2007b). Motivation to learn was also predicted by agreeableness, while emotional stability fostered transfer motivation.

### 7.5.5 Perceived utility/ value

In support of Burke and Hutchins, the current review found that people who perceive that training is useful learn and transfer more. Antle et al's (2008) findings signal the importance of explaining the relevance of training to delegates, and identifying staff who are ready to learn. Usefulness ratings have been related to the outlining of barriers to using the learning on the job during training (Antle et al., 2010). Antle et al proposed that attitudes towards controversial topics could be changed through training by addressing concerns around implementation of new learning; this leads to increased perception of utility, increased perception of importance of topic (attitude change), learning and finally transfer (ibid). Utility has also been found to improve transfer through perception of the learnt technique being effective with clients (Kennedy-Merrick *et al.*, 2008) perception of relevance to job role (Meyer *et al.*, 2007; Stolee et al., 2005; Subedi, 2006), and perceived relevance to learning needs (Meyer *et al.*, 2007). Perceived practical relevance has also been linked to transfer motivation (Liebermann & Hoffmann, 2008). These findings imply that training selection should happen strategically to meet learning, job and where applicable client needs, and

training should be close to the practical settings of delegates and address potential barriers to transfer.

#### 7.5.6 Career/ job variables

Only 2 of the dimensions noted in Burke and Hutchins were covered in this review. Career exploration is a dimension referring to “purposeful activities that are directed toward enhancing self and environmental knowledge... in order to foster progress with their career development” (Rowold, 2007a, :44). Dimensions of the career exploration scale, a high overall score, and satisfaction with information were found to predict post training behaviour, measured in an end of training role play exercise. The authors suggest that interventions to maximise employee’s focus on their career, and improve “internal search strategies” could improve training performance.

A study by Velada and Caetano (2007) found that occupational satisfaction was a predictor of perceived learning, and perception of learning mediated the relationship between occupational satisfaction and transfer. This implies that individuals who are satisfied with their occupation are more likely to learn and transfer training to work. These results support the findings of Burke and Hutchins, in that focus and commitment to job and career can positively influence transfer.

#### 7.5.7 Locus of control

Although Burke and Hutchins recommended further research on this construct, none was found in this review. A related factor, job control, was also found to have a slightly higher influence on idea generation and implementation than a creativity training

programme. Job control relates to autonomy and opportunity to experiment and apply new ideas (Birdi, 2007).

#### 7.5.8 Other factors not included in Burke and Hutchins:

Burke and Hutchins' review called for more research on goal orientation, which a number of studies have since investigated. Tziner, Fisher et al (2007) noted that performance goal orientation, where individuals seek to demonstrate competence and have a strong desire to impress others had a negative effect on supervisor assessed performance whereas learning goal orientation, where learning rather than performance is the goal, positively predicted transfer. This finding supports research by Chiaburu and Tekleab (2005) who noted a strong, negative relationship between motivation and both types of transfer when participants had a high performance goal orientation. This implies that high motivation is only a predictor of transfer if the goal orientation is one of learning, not performance. Goal orientation has also been found to have an interaction effect with culture (along the individualist/ collectivist dimension) on transfer outcomes (Rogers & Spitzmueller, 2009). Performance goal orientation was found to be negatively related to self-efficacy, while proximal factors such as self-efficacy, valence and expectancy mediated the relationship between performance goal orientation and goal intention (Smith *et al.*, 2008). The findings imply that a learning goal orientation should be encouraged in the workplace, and by using training conditions that activate learning goal frameworks (Rogers & Spitzmueller, 2009) as people with learning goal orientation are more likely to transfer; this finding is supported by Blume et al's metaanalysis (Blume *et al.*, 2010).

In an attempt to simplify existing transfer models, Leimbach (2010) combined the constructs of self-efficacy, intent to use, motivation to learn and career goal alignment into one construct termed “learner readiness”. A metaanalysis showed that the combined effect of these factors had the potential to increase transfer by up to 70%. Other studies measured learner readiness as a construct in its own right; high levels have been linked to use and reinforcement of child welfare practice skills (Antle, Barbee & van Zyl, 2008) and training transfer (Devos *et al.*, 2007). However, the reverse was found in one study (Sullivan *et al.*, 2009). This was identified as a counterintuitive finding, and the authors suggested that people high in learner readiness may view learning as a lifelong pursuit, so rated transfer lower as they knew it would take longer than the 3 month follow up period to fully achieve.

Further evidence indicates that learner readiness alone is not sufficient for transfer to occur. Attitudes towards the topic (Antle *et al.*, 2010) and orientation to the training programme and goal setting before beginning the training (Austin *et al.*, 2006) were highlighted as equally or more important to transfer than learner readiness while Antle, Barbee *et al.*'s findings were achieved in conjunction with management support.

Computer attitudes have been described as a type of learner readiness in the specific context of e-learning (Park & Wentling, 2007), and affected perceptions of usability of e-learning courses which in turn affected levels of transfer.

Supervisory readiness was also identified; one study recommended that supervisors are orientated to a training programme, as well as delegates, before delegates attend. This can assist with supervisory support, an important component of transfer (Austin *et al.*, 2006).

Participants' relevant ideological and theoretical attitudes have also been explored in relation to their effect on transfer. One study which aimed to teach motivational interviewing skills to staff working at substance abuse treatment facility found that staff with lower endorsement of the disease model of addiction had higher motivational interviewing skills at baseline, which remained at follow up (Baer et al., 2009). Attitudes to older people were perceived to affect training transfer in long term care (Stolee *et al.*, 2005). Attitudes to applying learning can also be influenced by the work environment (Schaumleffel & Backlund, 2009).

Switzer, Nagy et al (2005) found that the reputation of a training programme- described as expectations about the quality of the course, and its job relevance- was correlated with pre-training motivation and transfer. This has implications around the importance of framing training opportunities as meaningful and job-relevant, rather than tick box activities- a sentiment supported by Tai (2006) who found that positive framing of training by the supervisor positively predicted self-efficacy and training motivation. However, another study (which used different measures) found that attitudes towards training had no impact on motivational constructs (Rowold, 2007b).

The impact of learning approach on transfer has also been investigated (Murphy & Tyler, 2005). Three approaches (deep: where the intention is to understand meaning; surface; where the intention is merely to reproduce information without further analysis; and strategic; characterised by effective time and effort management to obtain the highest possible grade) were analysed. Using a verified measure, a deep approach was found to best predict training transfer, while neither exam nor

assignment grades were related to transfer. Further research is needed to uncover what structures can encourage a deep approach to learning.

A number of studies have found that delegate demographics have no effect on transfer or its antecedents (Chiaburu & Lindsay, 2008; Gegenfurtner *et al.*, 2009; Velada *et al.*, 2007). However another study found that some delegate characteristics including country of origin, age and job role did affect the degree of learning (Johnson *et al.*, 2006); however all of these factors may be proxies for other factors. A study conducted on Cambodian bank staff found that effective training could make up for poor education (Chen, Sok & Sok, 2007).

Other significant demographic factors include ethnicity (in relation to use of diversity training transfer strategy use) (Roberson, Kulik & Pepper, 2009) and gender (Chen, Takeuchi & Wakabayashi, 2005; Sullivan *et al.*, 2009). Chen, Takeuchi *et al.* found an interaction effect between gender, workplace support and training incentive. The authors suggested that uncovering training incentives would moderate the interaction effect between supportive work environment and gender, and organisations should rely on both a supportive environment and training incentives to motivate male and female managers.

Length of experience in a job was the only demographic factor to influence perceptions of factors affecting transfer; people with under 1 years' experience perceived higher organisational and supervisor support than people with over a years' experience (Petty, Lim & Zulauf, 2007). The authors concluded that demographic factors, rather than instructional methods (face to face versus e-learning) have the



most impact on perceptions of factors affecting transfer; however no measure of actual transfer was taken.

### 7.5.9 Summary of learner characteristics

The table below summarises Burke and Hutchins' findings, and the insights added by this review, by variable.

<b>Variable</b>	<b>Burke and Hutchins' findings</b>	<b>This review adds:</b>
<b>Cognitive ability</b>	Strong or moderate relationship with transfer	Corroborated by Blume's review, though little research has been done recently.
<b>Self-efficacy</b>	Strong or moderate relationship with transfer	Corroborated: may be a direct or indirect relationship, through other transfer antecedents. Can be affected by workplace factors.
<b>Pretraining motivation</b>	Strong or moderate relationship with transfer	Corroborated.
<b>Motivation to learn</b>	Minimal empirical research exists. Research is needed to clarify or build findings.	Strong to moderate link with transfer, and transfer antecedents.
<b>Motivation to transfer</b>	Minimal empirical research exists. Research is needed to clarify or build findings.	Moderate relationship with transfer; affected by workplace factors.
<b>Extrinsic vs. intrinsic motivation</b>	Mixed support. Research is needed to clarify or build findings.	Some evidence on influences of extrinsic and intrinsic motivation.
<b>Anxiety/ negative affectivity</b>	Strong or moderate relationship with transfer	No further evidence found.
<b>Conscientiousness</b>	Mixed support. Research is needed to clarify or build findings.	Moderate relationship with transfer.
<b>Openness to experience</b>	Strong or moderate relationship with transfer.	Mixed support, for this and other personality dimensions.

	Research is needed to clarify or build findings.	
<b>Extroversion</b>	Minimal empirical research exists. Research is needed to clarify or build findings.	Mixed support, for this and other personality dimensions.
<b>Perceived utility</b>	Strong or moderate relationship with transfer	Corroborated.
<b>Career planning</b>	Strong or moderate relationship with transfer	Minimal additional evidence found.
<b>Organisational commitment</b>	Strong or moderate relationship with transfer	No additional evidence found.
<b>External vs. internal locus of control</b>	Mixed support. Research is needed to clarify or build findings.	No additional evidence found.
<b>Additional factors</b>		
<b>Goal orientation</b>	Recommended further research on topic	Strong or moderate relationship with transfer and its antecedents.
<b>Learner readiness</b>	Not addressed.	Mixed findings. Further research needed.
<b>Attitudes (to training and to topic)</b>	Not addressed	Mixed findings. Further research needed.
<b>Demographics</b>	Not addressed	Mixed findings. Further research needed.

Table 8: Summary of learner characteristics

Blume et al's meta-analysis which controlled for the effects of same source and same measurement context bias found that in terms of trainee characteristics cognitive ability, conscientiousness, and voluntary participation in training had moderate relationships with training transfer. Small to moderate relationships were found with neuroticism, pretraining self-efficacy and motivation. There was some support for elements of the Big Five personality dimensions, as well as some types of goal

orientation. Findings related to personality are mixed, and Rowold (2007) suggests that rather than concluding that particular personality characteristics are universally important, attention should be paid to the personality demands of trained behaviours and their congruence with delegates' personalities. It may be that people with relevant traits are more motivated to learn and apply training. The same may be true of attitudes; practically, this could mean for example providing interventions to reduce ageist attitudes before training on other aspects of care. Further, training should be tailored to personality type; e.g. role play for extroverts, self-study for introverts, and peer coaching for people with emotional instability. This suggests a potential useful new avenue of transfer research, and one that takes account of the principles of adult learning (Knowles, 1990). While the transfer literature appears to focus on defining the ideal delegate in terms of transfer potential, adult learning principles discuss designing learning opportunities to fit the individual and their experience. The transfer literature could benefit from accommodating such principles.

A key concept appears to be self-efficacy; it has been related to reactions, learning and transfer, and lack of it appears to pose a barrier to applying learning. Interventions to increase self-efficacy have successfully increased transfer. Opportunity to use skills may provide an important role in facilitating experimentation with new skills, increasing trainees' confidence in their abilities. Whether it works directly or indirectly through concepts such as motivation to learn may, practically speaking, be irrelevant. Other studies have shown self-efficacy alone may not be enough to ensure transfer; support may be needed too. Motivation is another trait that is influenced by workplace factors, such as transfer climate, and support. The numerous forms of motivation have

a strong to moderate relationship with transfer, and numerous authors suggest that practical interventions such as preparation for training can increase motivation to attend, learn and transfer. Such interventions may also increase perceived utility, another important concept as well as learner readiness, which needs further research. The influence of goal orientation has been clarified since Burke and Hutchins' paper, and appears to be important. A learning, rather than performance goal orientation can lead to higher levels of transfer, and such an orientation can be encouraged by workplace factors.

## **7.6 Intervention design and delivery**

The second of Baldwin and Ford (1988)'s training input categories is intervention design and delivery. Numerous constructs influence transfer either directly, or indirectly through learning (Burke & Hutchins, 2007).

A metaanalysis by Leimbach (2010) found that combined learning transfer design features, including practice and modelling, goal setting, and application review (how to apply learned skills to specific work tasks) could potentially increase transfer by up to 37%. When combined with learner readiness and workplace factors, an increase in transfer of up to 186% could be obtained, depending on the context. A similar study by Saks and Belcourt (2006) found that pre-training activities, including trainee input, trainee and supervisor involvement and trainee preparation explained 21% of the transfer variance (rated by training professionals). Activities during training accounted for 20% of the transfer variance, while post training activities accounted for 24%. The only significant factor during training was identical elements (making training as much like the workplace as possible) - relapse prevention, feedback and reinforcement, and

goal setting had no significant impact. However a Portuguese study found that transfer design, as measured by a scale from the Learning Transfer System Inventory (Holton, Bates & Ruona, 2000) positively predicted transfer (Velada *et al.*, 2007).

### 7.6.1 Needs analysis

Burke and Hutchins outlined the rationale for needs analysis; training is best used to address knowledge, skills or ability deficits, and using training as a way to remedy performance deficit stemming from an inadequate work environment is unlikely to be effective. However they wrote that few studies had addressed the link between needs analysis and transfer. Recent research showed that instruction targeted to specific learning needs was more effective than non needs based training (Chow, Woodford & Showers-Chow, 2008). A metaanalysis of training effect sizes by Taylor, Russ-Eft et al (2009) found that across rating source, training where content was derived from an analysis of task and skill requirements resulted in larger transfer effect sizes. Providing only job related or needs based training was suggested as one of the ways that training transfer in Nepal could be improved (Subedi, 2006).

### 7.6.2 Learning goals

Learning goals were found to have a strong to moderate correlation with transfer by Burke and Hutchins, a finding supported here. Learning goals can be proximal (short term, benchmarking goals) or distal (long term, outcome goals). In an experimental study, Brown and Warren (2009) concluded that distal goals resulted in higher levels of transfer and self-efficacy. Being urged to “do your best” did not facilitate transfer in the long run. The importance of creating learning goals prior to attending, and revising

them as a longitudinal training programme progresses has been highlighted. Discussion of learning goals with senior figures was also seen as useful (Austin *et al.*, 2006).

The type of goal has also been shown as an important consideration; Nikandrou, Brinia *et al* (2009) noted that self-development, rather than job development related goals resulted in less direct transfer (applying the knowledge and skills acquired to work) than indirect transfer (skills acquired indirectly from training, such as confidence).

### 7.6.3 Content relevance

The concept of identical elements, which suggests that a training programme is more effective if training elements are identical to the organisational context (DeVoge & Bass, 2007) has been studied in recent years. DeVoge and Bass found that the use of identical elements was supported for role specific training, while 'general principles' are useful for when task demands or situations change over time. This corroborates previous work. However the study took place in a lab, used students rather than professionals and involved very short time scales- the pre-test, learning and post-test was all carried out in under 2 hours- so generalisability is questionable. Practice based tasks were rated as one of the components of a post graduate diploma in mental health care that most helped transfer (Gauntlett, 2005), while perceived practical relevance was an important antecedent of transfer in a study of banking staff (Liebermann & Hoffmann, 2008).

The importance of content focus (what is being learned, not how it is learned) was studied in a survey of the effectiveness of teacher training. Content focus (along with follow up) had the biggest impact on self-reported knowledge levels. Results also suggested that programmes with a stronger focus on how to teach specific subject

matter facilitated more active, school based, professional learning processes (Ingvarson, Meiers & Beavis, 2005). These findings support the assertion that trainees must perceive a close relationship between training content and work tasks to ensure transfer (Burke & Hutchins, 2007).

#### 7.6.4 Instructional strategies and methods

Burke and Hutchins found that strategies including practice and feedback, overlearning, cognitive overload, active learning, behaviour modelling, and error based examples influenced transfer. A number of these strategies were not addressed in the studies included in this review, and some others were found- for example, context tailored training was not found to lead to significantly different transfer levels than ordinary workshops (Baer *et al.*, 2009). An important function of the transfer literature is to inform practice, yet one study found that knowledge of transfer was variable among training providers (Burke & Collins, 2005). Studies should consider ways of disseminating their work to providers in order to maximise the impact of research.

Taking the issue of practice and feedback first, a number of experimental studies have been undertaken recently. Template creation, a method which utilises public feedback on performance to encourage learning and performance improvement, was more effective than conventional training in a sales context (Lyons, 2008). Another method, simulation training, involves three features which were expected to increase transfer; a more realistic context (incorporating the “identical elements” principle (Saks & Belcourt, 2006), guaranteed feedback, and paced learning. In an experimental field study, simulation training was found to have a more positive result on call centre

transfer outcomes than role play (Murthy *et al.*, 2008). However it is unclear how well the method would generalise to other contexts. Another study found that opportunity to practice negotiation skills through role play was attributed to the successful transfer of a 14 week course on negotiation (Taylor, Mesmer-Magnus & Burns, 2008), while a metaanalysis showed that opportunity to practice skills resulted in larger effect sizes (Taylor, Russ-Eft & Taylor, 2009). The question of whether spaced training is more conducive to transfer than massed training has also been addressed. In an experimental study, content and total duration were the same, but massed trainees attended 6 days of training in a row, while spaced trainees had a 4-7 day break between each day long unit. Spaced training was found to have a significantly more positive impact on organisational goals and had higher perceived content validity which the authors speculate may have been responsible for better training outcomes (Kauffeld & Lehmann-Willenbrock, 2010). Follow up or “booster” sessions have a similar impact to spaced training (Morgan *et al.*, 2007). Informal learning (as opposed to classroom learning) was rated better for gaining practical competencies in teacher training, and was also more positively related to transfer (Burns, 2008). Further research is needed to clarify the mechanism of action by which the training was effective, and whether it could be used in other sectors.

Overlearning and cognitive overload were not investigated in the studies included in this review.

Active learning is an involved, rather than passive activity for the learner (Burke & Hutchins, 2007). The importance of motivating participants to use skills as well as teaching them, was shown in a comparison of three programmes on the same topic



(Birdi, 2007). Interactive training was perceived to be an important factor in ensuring transfer by a sample of training professionals (Burke & Hutchins, 2008), and this premise was supported by an evaluation of youth worker training (Collins, Hill & Miranda, 2008) where delegates valued the chance to share best practice, reflect on strengths and challenges of a new approach and discuss the challenges of overcoming staff resistance to change. Opportunities for active learning and reflection on practice (Ingvarson, Meiers & Beavis, 2005) and discussion and role play (Cole, 2008) were also valuable in instigating behaviour change.

Other components of training that have been deemed useful for transfer include study packs, and in some cases assignments and portfolios (Gauntlett, 2005).

A study on diversity training found that skill based learning was positively related to transfer, while cognitive and affective (attitude) learning had no relationship with transfer strategy use. Skill based learning was found to be more important when delegates worked in an environment that provided few consequences for demonstrating positive diversity behaviour (Roberson, Kulik & Pepper, 2009).

No studies were found concerning error based examples training, where instructors share with trainees what can go wrong if they don't transfer their learning to practice. Burke and Hutchins found that pilots' and fire-fighters' performance was enhanced when they watched more mishaps occur. This review found a different approach to using errors- in the form of error management training, a technique that encourages errors in order to learn from mistakes. A metaanalysis of 24 studies found that error management training was more likely to lead to improved long term outcomes, compared to other methods which may lead to better outcomes measured within

training. Error management training was also more effective for adaptive tasks (far transfer) than analogical (near transfer). However almost all studies involved software skills training, and were lab based so further work is needed before the findings can be applied to real world training in other sectors (Keith & Frese, 2008).

The length of training interventions was addressed in an experimental study of managerial disciplinary fairness skills training. Participants on the extended programme had significantly higher post-test behavioural scores than the shorter, or control (no training) groups (Cole, 2008). Conversely, obstacles to skill acquisition and application on a postgraduate diploma in effective mental health community care included insufficient training (Gauntlett, 2005). Duration was identified as an important structural consideration of teacher training programmes as it had an indirect effect on training outcomes through related factors including active learning, content focus, collaboration and feedback (Ingvarson, Meiers & Beavis, 2005).

Another method not mentioned by Burke and Hutchins is blended learning, which mixes online and face to face learning modes. It is being increasingly adopted by organisations in the hope that it will solve transfer problems, as well as lending other educational benefits (Lee, 2010). Lee surveyed learners to find out which factors they thought enhanced blended learning effectiveness; results included, for the online part, informing learners of purpose of training; activating prior knowledge; providing self-assessment; making lectures engaging, interactive and teaching principles underlying concepts; and providing opportunities to interact with tutors. Linking on and offline content was also important. Offline, providing opportunities to practice, evaluating transfer, providing feedback and job aids, and encouraging action plans helped.

### 7.6.5 Self-management strategies

Self-management strategies provide trainees with the necessary skills to transfer their learning to the workplace, and may include self-generated positive feedback, goal setting, action planning, and relapse prevention techniques (Burke & Hutchins, 2007). Ladyshefsky (2007) found that peer coaching in a management development programme helped to develop meta-cognitions (awareness and control of the learning process). Other methods that appeared effective in supporting transfer included reflective journaling, goal setting and workplace assignments (Ladyshefsky, 2007) relapse prevention (Blume *et al.*, 2010) and actions plans and self-assessments (Lee, 2010). Trainee cognitions entail thinking about how to use the training in the workplace, and have been found to act as a mediator between individual factors, such as self-efficacy and motivation to learn, and transfer (Chiaburu, Van Dam & Hutchins, 2010). Tews and Tracey (2008) found that both self-coaching- “an autonomously managed supplement in which trainees reflect on their performance and establish transfer enhancement goals for several weeks upon completion of training” (p378) and upward feedback, where individuals receive feedback from subordinates positively affected transfer, compared to classroom training alone.

A number of studies have also studied self-management training as standalone intervention. Pattni, Soutar et al (2007) found that a short self-management intervention helped to improve the self-efficacy of bank staff, although the performance of the control group also improved. This may have been due to contamination effects (experimental group sharing their learning), or the effects of training individuals on the team performance as a whole. Self-management strategies

also increase self-efficacy across different cultures (Pattni & Soutar, 2009). Both studies used a short (3 hour) intervention; this is a cost effective way to provide the tools for employees to improve their self-efficacy, which improves performance and supports training transfer.

#### 7.6.6 Technological support

Burke and Hutchins cite the need for further research on methods such as e-coaching, EPPS (Electronic Performance Support Systems) and nagware but only reports of blended learning (Lee, 2010) and e-learning (Park & Wentling, 2007) were found in this review.

#### 7.6.7 Other factors not included in Burke and Hutchins

Peer coaching was perceived as a key to transformation in a study of UK education; the intervention worked best where coaches had designated time out to coach and develop coaching with their organisation, and worked in conjunction with other programme elements and workplace support (Browne, 2006). Coaching, across all stages of the transfer process (before during and after) was perceived to be an effective transfer device by trainers (Burke & Hutchins, 2008). Qualitative comments (from a very small sample) highlighted that contextual features can enable or disable the effects of peer coaching (Ladyshevsky, 2007).

Training professionals perceive trainer characteristics to be important to transfer (Burke & Hutchins, 2008) and believe much of the responsibility for transfer lies with them (Yaw, 2008) rather than being distributed over the trainer- delegate- manager triad as has been suggested by other authors (Burke & Hutchins, 2008). Trainer

credibility was cited as important for transfer by mental health practitioners (Gauntlett, 2005). Delivering training in a positive way, using an approach that was respectful of the good work that workers were already attempting to do contributed to it being well received (Collins, Hill & Miranda, 2008). Trainers' quality ratings were the only factor related to an increased commitment to using learning, measured pre-post and pre- 6 months post training (Johnson *et al.*, 2006). In a case study of adult learners, instructor qualities of empathy, authenticity, sincerity, and high integrity were identified by learners as being important for their learning and transfer (Taylor, Ayala & Pinsent-Johnson, 2009).

#### 7.6.8 Summary of intervention design

Table 9 summarises Burke and Hutchins' findings, and the insights added by this review, by variable.

<b>Variable</b>	<b>Burke and Hutchins' findings</b>	<b>This review adds:</b>
<b>Needs analysis</b>	Minimal empirical research exists. Research is needed to clarify or build findings.	Some evidence to corroborate relationship between needs analysis and transfer.
<b>Learning goals</b>	Strong or moderate relationship with transfer	Corroborated.
<b>Content relevance</b>	Strong or moderate relationship with transfer	Corroborated.
<b>Practice and feedback</b>	Strong or moderate relationship with transfer	Corroborated.
<b>Over-learning</b>	Research is needed to clarify or build findings.	No additional evidence found.

<b>Cognitive overload</b>	Research is needed to clarify or build findings.	No additional evidence found.
<b>Active learning</b>	Minimal empirical research exists. Research is needed to clarify or build findings.	Some evidence to corroborate relationship between active learning and transfer.
<b>Behavioural modelling</b>	Strong or moderate relationship with transfer	No additional evidence found.
<b>Error-based examples</b>	Strong or moderate relationship with transfer. Research is needed to clarify or build findings.	No additional evidence found. However evidence was found to support effectiveness of error management training in certain contexts.
<b>Self-management strategies</b>	Mixed support. Research is needed to clarify or build findings.	Some evidence to support relationship with transfer, including as a standalone intervention.
<b>Technological support</b>	Minimal empirical research exists. Research is needed to clarify or build findings.	No additional evidence found.
<b>Additional factors</b>		
<b>Peer coaching</b>	Not addressed	Some qualitative evidence of relationship with transfer. Further research needed.
<b>Trainer characteristics</b>	Not addressed	Some, mainly qualitative, evidence of relationship with transfer. Further research needed.

**Table 9: Summary of intervention design**

Although the influence of individual characteristics and workplace factors may be greater, intervention design and delivery is also important in transfer. Needs analysis, learning goals, content relevance and practice and feedback are all factors to consider to encourage transfer when designing interventions. While interventions such as

identical elements are useful for training in specific tasks, teaching general principles may work better when situations or task demands change over time; this is relevant to safeguarding adults training as no two abusive situations will be the same. Opportunity to practice and receive feedback on skills during training may improve transfer through increasing self-efficacy, among other mechanisms. Active learning is likely to support trainees to consider how the training applies to their work, although the term is used to cover a variety of techniques. Excluding findings with SS/ SMC bias, Blume et al (2010) found that interventions including optimistic preview, goal setting and relapse prevention had small to moderate relationships with transfer (to be interpreted with caution due to small sample size).

Length of training may also be worthy of further attention in the transfer literature, as organisations may be willing to invest more in providing longer courses if it can be shown to lead to a higher return on investment in terms of transfer. Spaced training, where delegates have an opportunity to try out new skills in the workplace between sessions, has had some support in the literature and appears to encourage other useful factors such as practice, feedback and content relevance.

The gap in the literature on self-management techniques highlighted by Burke and Hutchins has been addressed, and both techniques incorporated into other programmes, and as standalone interventions, appear to be effective aids to transfer. Again this may link to self-efficacy and motivation; peer coaching is another variable in need of further research. Characteristics of the trainer have not previously been highlighted as important, but this review found some evidence of the significance of characteristics including competence and credibility to transfer.

## 7.7 Work environment factors

Work environment factors have been highlighted as important because without support, transfer can decay over time (Saks & Belcourt, 2006). Burke and Hutchins noted the expansion of the number of workplace factors addressed in the transfer literature since Baldwin and Ford (1988)'s initial model. They discussed strategic linkage of training, transfer climate, supervisory and peer support, opportunity to perform and accountability as important transfer considerations. More recently, barriers to transfer and barriers to participating in training in the first place have been found, in a small scale study, to have many commonalities. Brown and McCracken (2009) outlined the importance of combining literatures to aid understanding in transfer; time, unsupportive culture, and trainee characteristics were found to be the biggest barriers to transfer, and mapped onto previous literature on barriers to participation. A metaanalysis by Leimbach (2010) found that using workplace related learning transfer tools could increase transfer by up to 79%. Peer support had the biggest impact on performance improvement.

### 7.7.1 Strategic link

A clear link between corporate strategy and management development programmes was significantly associated with management development effectiveness in Australia's top 200 companies (D'Netto, Bakas & Bordia, 2008). It also acted as a mediator between individual initiative (the active role that people must play in their own development) and management development effectiveness. Management buy-in was a prerequisite factor for participation in a successful training programme aiming to improve performance in nursing homes (Morgan *et al.*, 2007). The programme



required commitment from all levels of staff, and learners received a stipend and a bonus for completing the programme. Participants reported improved morale, confidence and job satisfaction as well as performance. A clear training policy and transparent, unbiased selection for training were factors highlighted as potentially improving transfer in Nepal (Subedi, 2006).

Conversely a lack of such a strategic link was highlighted as a reason for the lack of transfer of teacher training in a case study of 5 teachers in Pakistan (Mohammed, 2006). A conflict between the schools' expectations and teacher education was reported, which made implementing new methods very difficult. Another failure of strategic link was reported by Sofo (2007) who suggested that a lack of involvement of supervisors in setting training objectives contributed to a lack of expectation, monitoring or follow up of transfer.

### 7.7.2 Transfer climate

Transfer climate refers to “those situations and consequences in organisations that either inhibit or facilitate the use of what has been learned in training back on the job” (Burke & Hutchins, 2007, :282). Burke and Hutchins (2007) identified the positive features of a transfer climate as cues that prompt trainees to use new skills, consequences and reward for not using or using skills, and social support from supervisors and peers. Building on this, the current review found a facilitative transfer climate positively affects transfer outcomes (Nijman *et al.*, 2006). Organisations with an openness to change (Baer *et al.*, 2009), or with an organisational learning culture (D'Netto, Bakas & Bordia, 2008) better support transfer. In fact organisational factors such as management support and climate for supporting the skill being trained have

been found to have more impact than training on behaviour, although there are questions over the measurement of these factors (Birdi, 2007). A large scale survey of teacher training effectiveness found that the professional community became a mediating influence on teachers' knowledge and practice (Ingvarson, Meiers & Beavis, 2005). Transfer climate has also been found to have different effects on male and female managers; Chen, Takeuchi et al (2005) found that when training was not clearly linked to promotion, a supportive work environment with regard to utilising newly learnt managerial skills had more influence on women than men. This interaction effect only took place where training incentives were low. This demonstrates the complexity of the interplay between factors that affect transfer.

Organisational factors have also been suggested as barriers to implementing new learning (Bayley et al., 2007; Browne, 2006; D'Netto, Bakas & Bordia, 2008; Green & Skinner, 2005; Kennedy-Merrick *et al.*, 2008; Nikandrou, Brinia & Bereri, 2009). In the context of youth work these barriers included staff resistance to change, low morale or burnout, financial issues, high caseload and turnover and oversaturation of mandatory training (Collins, Hill & Miranda, 2008). A qualitative study found that poor transfer was attributed to a lack of consideration of transfer, absence of learning culture, and a perception of training being a "bad but necessary investment" (Nikandrou, Brinia & Bereri, 2009, :265). These are factors that all arguably contribute to the transfer climate.

Another study on pre-school teacher training in Spain found that although teachers asserted that they continuously transferred training to practice, they were unable to give examples or frequency; the researchers commented on a lack of systems to

ensure transfer, identifying that transfer was dependent on the “individual will of each professional” and this was insufficient (Pineda-Herrero *et al.*, 2010: 420).

The Learning Transfer System Inventory was noted by Burke and Hutchins (2007) as being a measure of individual, intervention and work environment factors. Its dimensions had been validated in numerous cultures but it remained untested in terms of its relationship to transfer. Some progress has been made in this area. One study found that numerous constructs were significantly correlated with training transfer self-reports. Significantly, no correlation was found between social supports (such as supervisor support) and transfer, which has discordance with previous literature (Devos *et al.*, 2007). The instrument has also been validated for use in Taiwan, where it was found that it can also be used in relation to affective training (Chen, Holton III & Bates, 2005).

Other studies have questioned the importance of workplace climate. Martin (2010) found that trainees who worked in a favourable climate showed higher supervisor-rated transfer than those in an unfavourable climate, but the authors noted that the effects of peer support, a more proximal factor, were larger than those of workplace climate. Elsewhere, climate was found to have no direct impact on learning or performance, though it did have an indirect effect through motivation to learn (Tziner *et al.*, 2007). It is possible that different methods of measuring climate, a complex construct, may be responsible for the contradictory findings; a review of measures of organisational climate conceded that all available measures were limited in some way (Scott *et al.*, 2003) and it is likely that measures of transfer climate face a similar problem.

Transfer climate has been subject to intervention in other studies. Morgan, Haviland et al (2007) found that by addressing the antecedent and post training conditions through providing supervision training to senior staff, offering incentives for attending training, and providing pre-training literacy programmes, transfer was improved. They posit that creating a culture that values training was the crucial factor.

### 7.7.3 Supervisor/ peer support

The supervisory role in transferring training to practice has been highlighted primarily as one of support (Burke & Hutchins, 2008). Burke and Hutchins noted that peer support has been more consistently linked to transfer than supervisory support, a finding replicated here, although both supervisor and peer support have been linked to higher perceptions of training utility (Sullivan *et al.*, 2009). Supervisor support has been positively related to transfer intention (Al-Eisa, Furayyan & Alhemoud, 2009) self-efficacy, motivation to learn, learning goal orientation and motivation to transfer more so than organisational support. It was suggested that supervisory support is a more proximal and concrete entity than organisational support (Chiaburu, Van Dam & Hutchins, 2010) or continuous learning culture (Chiaburu & Tekleab, 2005) so has more effect on transfer. Martin (2010) suggested that the proximal nature of peer compared to organisational support may be responsible for its larger effect on transfer; his longitudinal questionnaire showed that peer support mitigated the effects of an unfavourable climate on transfer. It appears that more proximal support may have more impact on transfer, though further research is needed to confirm this.

In a Delphi study, Stolee, Esbaugh et al (2005) found that management support was rated the most important factor contributing to the effectiveness of continuing

education in long term care, a finding supported in a later evaluation of a long term care training intervention (Stolee *et al.*, 2009). Line manager support of programmes led managers to become more enthusiastic and active in their own development (D'Netto, Bakas & Bordia, 2008) and positively impacted on trainee's judgements of the value of the programme, while discussions, encouragement and coaching from managers facilitated transfer (Gilpin-Jackson & Bushe, 2007). Clinical supervision had a small impact on the application of communication skills training in practice; the effect size was attributed to the brevity of the supervision intervention and timing of the post- training test (Heaven, Clegg & Maguire, 2006). Other work has suggested that supervisors should be familiar with the program to facilitate dialogue about it (Austin *et al.*, 2006) trained as transfer agents (Al-Eisa, Furayyan & Alhemoud, 2009) and involved both pre and post training (Austin *et al.*, 2006; Saks & Belcourt, 2006).

However other studies have challenged the importance of supervisor support (Devos *et al.*, 2007; Velada *et al.*, 2007); one study found no significant difference in terms of training transfer between groups who differed in supervisor support, although qualitative data suggested that the support had been extremely helpful (Kennedy-Merrick *et al.*, 2008). Another study (Nijman *et al.*, 2006) found that supervisor support had a negative effect on transfer outcomes and motivation to transfer, though it positively predicted a facilitative transfer climate. Participants in the study worked autonomously, and the authors suggest that the negative effect of supervisor support may be due to perceptions of supervisors being coercive or redundant. Sofo (2007) found that the importance of support from supervisors and colleagues differed according to job type. Another study showed that lack of supervisory support could be

overcome (Nikandrou, Brinia & Bereri, 2009). Concentrating on improving the transfer climate rather than supervisory support specifically may be more likely to improve transfer in such cases.

Supervisor support can only be of value if supervisors are competent in their role. A social care based study found that providing supervision training, in addition to other programmes for care staff, had a positive effect on transfer by addressing pervasive problems with communication and teamwork between the levels of staff. The intervention was multifaceted, also involving incentivised and tailored training and management buy in (Morgan *et al.*, 2007), again emphasising the complex and context specific nature of successful transfer interventions.

As noted, peer support of new learning seems to be important to transfer (Burke & Hutchins, 2008). One study found that peer support was in fact more highly correlated to transfer than supervisory or organisational support, both for maintenance and generalisation (Chiaburu, 2010). Having a “critical mass” of workers attend a course was found to assist transfer of a mental health practitioner qualification (Gauntlett, 2005) and a management development programme (Gilpin-Jackson & Bushe, 2007) while another study found that delegates thought offering the training to the whole workforce would be beneficial (Zweibel *et al.*, 2008). Critical mass may be effective for peer support reasons, or because delegates see evidence of the training being transferred by others. A Danish study found that apprentices helped each other make sense of college learning in the work context, with older and more experienced apprentices providing support around explaining the relevance and application of new learning at work (Nielsen, 2009). Support from peers is also important for transfer in

long term care. Stolee, Hillier et al (2009) noted that success factors in their programme (PIECES) for nursing home staff included the availability of PIECES- trained staff, and support and commitment of peers, specialists and physicians. Lack of PIECES- trained staff and staff support were constraining factors.

Conversely, a lack of colleagues using trained methods (or critical mass) has been cited as a barrier to using cognitive behaviour therapy techniques (Kennedy-Merrick *et al.*, 2008). In a small sample, qualitative follow up of a teacher training programme, long term impact of training was found to depend mainly on contextual aspects such as support from colleagues and students (Stes, Clement & Van Petegem, 2007). Enthusiastic reactions from colleagues and students encouraged the use of new teaching strategies, whereas a lack of consensus or collaboration with colleagues, or student apathy constrained transfer.

Role support may also be important; this was defined in a study of drug and alcohol nurses as

“the availability of others with whom the nurse would readily and easily discuss personal difficulties, clarify professional responsibilities and formulate the best response to clinical issues” (Ford, Bammer & Becker, 2009, :114)

A large scale cross sectional survey on the impact of training and role support on nurses’ therapeutic attitude (engagement with the patient) found a strong interaction effect whereby an increase in the level of education impacted on attitude once the level of role support was at least moderate. Education alone was not sufficient to improve attitude- the authors suggest that education on its own could lead to a *loss* of confidence if new behaviours are not supported in the workplace (Ford, Bammer &

Becker, 2009). Similarly, Meyer, Lees et al (2007) found nurses needed time to demonstrate competencies at work, as well as training. The premise that a workshop alone is not enough to change behaviour was echoed in a study of ethics training for office professionals, which found that although there was an effect immediately after training, this had disappeared at 3 month follow up. A lack of support was suggested as a factor in this (Frisque & Kolb, 2008), and has been suggested as a factor contributing to failure to transfer in other studies (Mohammed, 2006).

Finally, the importance of instructors working with supervisors to support adult learners with low skills to apply their learning at work was highlighted in a case study by Taylor, Ayala et al (2009). Open communication channels between the learning and work context were identified as helpful because issues could be addressed early on, as was focussing on broad and complex learning activities that could easily be transferred to work. This also links with training being relevant and job related.

#### 7.7.4 Opportunity to perform

Qualitative studies have highlighted the need for supervisors and organisations to provide delegates with opportunities to use new learning (Austin *et al.*, 2006; Burke & Hutchins, 2008; Lee, 2010; Nielsen, 2009). Opportunity to use new learning has been positively correlated with training transfer (Devos *et al.*, 2007) and the effectiveness of a management development programme (D'Netto, Bakas & Bordia, 2008). Nurses also highlighted opportunity to perform as important in transferring clinical skills training to practice; taking on new or extended roles related to the training positively affected transfer (Meyer *et al.*, 2007). Limited opportunity to practice new skills has been attributed to organisational constraints including lack of management support,



caseload, time, resources and unsuitable client case mix (Gauntlett, 2005) lack of materials and workload (Sofo, 2007), and time, resource pressures, overwork and fatigue (Zweibel *et al.*, 2008). However, Zweibel *et al* also found that individuals made their own opportunities to solve conflict, through taking on additional responsibilities, mentoring, coaching and further research. These findings support Burke and Hutchins' assertion that opportunity to perform is a crucial component of transfer, and also highlight the interconnectedness of the issue with other workplace factors.

### 7.7.5 Accountability

Burke and Hutchins identified accountability, "the degree to which the organisation, culture and/or management expects learners to use trained knowledge and skills on the job and holds them responsible for doing so" (p282), as an understudied variable, and this review supports that. Only one study addressed the issue, finding that responsibility for transferring learning was perceived by training professionals to be shared by trainers, managers and delegates (Burke & Hutchins, 2008).

### 7.7.6 Other factors not included in Burke and Hutchins

Trainers (Burke & Hutchins, 2008) and Nepalese employees (Subedi, 2006) perceived that evaluation of training was an important support to transfer, because measuring transfer positively affects trainees' use of new learning at work (Burke & Hutchins, 2008). Ideas for encouraging evaluation included not awarding certificates until managers or delegates confirmed that transfer had occurred. Similarly, Velada, Caetano *et al* (2007) suggested that organisations should conduct follow up assessments of transfer and retention of learning to maximise the impact of training. Conversely, lack of follow up or evaluation was suggested as a reason why

management development skills are not transferred to practice (D'Netto, Bakas & Bordia, 2008).

Related to supervisor and peer support is the issue of feedback on performance. Although in Velada et al's study supervisor support was not found to predict transfer, performance feedback significantly predicted it (Velada *et al.*, 2007). A regression analysis in another study showed that helpfulness of feedback was positively related to motivation to transfer. The amount of people providing feedback and helpfulness of the feedback were positively related to training transfer, while the average frequency of feedback was negatively related to transfer. There was no effect of feedback source (Van den Bossche, Segers & Jansen, 2010). However the issue of content and purpose of feedback was not explored.

Wider contextual factors have also been considered. One study looked at the effect of workplace design on transfer on a supervisory skills programme, using an ethnographic approach. Design factors were a major influence of transfer, after management support (though this may have been due in part to the focus of the study), with issues such as visual and acoustic privacy identified as helping or hindering transfer of supervisory skills. The author also suggested that closer matching of training to the workplace environment (in terms of noise, distractions, space etc.) would better prepare delegates for transfer (Kupritz, 2006).

The relationship between a leader and a follower, or "LMX" (Scaduto, Lindsay & Chiaburu, 2008) has also been investigated in terms of its effect on transfer. Scaduto et al found that LMX was positively correlated with transfer, generalisation and maintenance, but the relationship was fully mediated by training motivation, and

outcome expectancy (a judgement of the likely consequence that behaviour will produce). The authors concluded that aspects of LMX such as supervisor support, reinforcement, incentives, cues, knowing where you stand with the leader and having confidence that they will help solve work issues helped to improve transfer by increasing training motivation and outcome expectancy; the social context of work is important (Scaduto, Lindsay & Chiaburu, 2008; Stes, Clement & Van Petegem, 2007).

A metaanalysis found that national culture in terms of “uncertainty avoidance” can affect the impact of safety training. This expands the focus on workplace factors to a new and wider system of influences, measurement of which poses a challenge. “Safety climate” was positively related to transfer of safety training, reinforcing the importance of alignment between strategic priorities and training provision (Burke et al., 2008). Training can also be affected by relevant world events. A international law enforcement training programme focussing on preventing international crime, including terrorism, found higher increases in self-reported knowledge gain in the cohort that attended just after the 9/11 terror attacks in New York. The cohort was also the only one (of 4) to report any agency-wide training transfer, though other cohorts did report individual transfer (Johnson *et al.*, 2006).

The impact of individualist vs. collectivist cultures on transfer outcomes has also been studied (Pattni & Soutar, 2009; Rogers & Spitzmueller, 2009). Rogers and Spitzmueller posited that intercultural differences can impact on how training knowledge is acquired and transferred. They found that collectivism significantly predicted motivation to learn and transfer outcomes. Culture was also found to interact with

goal orientation (learning or performance) to affect transfer outcomes (Rogers & Spitzmueller, 2009).

### 7.7.7 Summary of work environment factors

Table 10 summarises the workplace factors discussed above. In a meta-analysis, Blume et al (2010) found that transfer climate had the highest relationship with transfer, followed by support and workplace constraints (which was negatively scored). Learning outcomes related measures such as post training self-efficacy and post-training knowledge had small to moderate effects on transfer, as did utility reactions.

<b>Variable</b>	<b>Burke and Hutchins' findings</b>	<b>This review adds:</b>
<b>Strategic link</b>	Minimal empirical research exists. Research is needed to clarify or build findings.	Some support for importance of strategic link to ensure transfer. Further research needed.
<b>Transfer climate</b>	Strong or moderate relationship with transfer. Research is needed to clarify or build findings.	Strong or moderate relationship with transfer supported. However more proximal factors may have a greater influence.
<b>Supervisory support</b>	Strong or moderate relationship with transfer. Mixed support. Research is needed to clarify or build findings.	Corroborated. The influence of supervisory support appears to vary according to other factors. These should be investigated further.
<b>Peer support</b>	Strong or moderate relationship with transfer.	Previous findings corroborated
<b>Opportunity to perform</b>	Strong or moderate relationship with transfer.	Previous findings corroborated
<b>Accountability</b>	Further research needed to	No additional evidence

	clarify or build findings.	found
<b>Additional factors</b>		
<b>Evaluation of training</b>	Not addressed	Some suggestion that consistent evaluation of training may aid transfer. Further research needed.
<b>Performance feedback</b>	Not addressed	Some evidence to suggest performance feedback may aid transfer. Further research needed.
<b>Wider contextual factors</b>	Not addressed	Some evidence to suggest wider contextual factors may impact transfer. Further research needed.

**Table 10: Summary of work environment factors**

Transfer climate encompasses many of the workplace factors noted here, but some are worth picking out individually. A positive climate has been strongly linked to transfer, and recent research has linked measurement of climate, for example by Holton et al’s Learning Transfer System Inventory, to transfer. Further research is needed to ensure that transfer climate measurement systems are not only valid but relate to the outcome they claim to measure the antecedents of.

The importance of supervisory support has led some authors to advocate training supervisors as ‘transfer agents’. It certainly appears that providing training or information about transfer may reduce misconceptions about the power of training alone to fix things reported in case studies or qualitative data. Raising awareness about transfer and its antecedents in organisations, as well as to training providers, would also increase demand for interventions that are supportive of transfer. This would also raise awareness about the importance of peer support (or role support) for transfer, which may be the most important workplace factor. Awareness of the importance of

measuring the impact of training may lead to increased evaluation of programmes, which would both potentially increase transfer in itself, and shed more light on the variables that impact in particular contexts.

## **7.8 Conclusions**

The review highlights the importance of carrying out context specific research. Because so many factors have been studied, over such a wide variety of contexts, it is difficult to definitively state which variables will affect transfer for any particular training programme, although some variables (e.g. self-efficacy, cognitive ability, opportunity to perform, transfer climate) do appear to be universally important. However, factors are likely to interact with each other, so the presence of one positive factor may not always predict transfer, especially if it is combined with a number of negative factors.

Furthermore many studies claim to show evidence of support for an intervention, or other variables' relationship with transfer, but they do not explain how this influence occurs, i.e. the underlying mechanism of action. Why is it that practice and feedback works? How do personality traits impact on transfer outcomes? These questions should be addressed in order to gain a better understanding of not just what works, but how interventions work, in order to understand the underlying programme theories.

The interdependence of factors is a nebulous but important question to address. For example, having a strong strategic link between organisational and training aims will likely lead to higher motivation to attend due to increased perceived practical relevance. Managers and peers are also likely to be supportive of behaviour. Therefore

trying to isolate individual factors may be less useful than defining how the variables interlink and connect in particular contexts. Having a training plan that fits with the strategic objectives of an organisation, and using a top down approach seems likely to have a better impact on transfer due to its likely impact on other transfer related variables.

The papers sampled rarely make reference to the vast amounts of literature on theories of adult learning. This is despite the resonance that many transfer-related factors have with such theories. The diagram below shows an adapted model of adult learning (Race, 2010), which depicts seven factors underpinning successful adult learning. Race uses evidence such as the review of learning styles in post -16 education by Coffield, Moseley et al (2004) to refute the idea of a learning cycle as advocated by theorists such as Kolb (1984); similar arguments have been made by other authors (Jarvis, 2006; Knowles, 1990). Instead of using a cycle, which he argues is simplistic, Race created a diagram in the style of “ripples on a pond”. This model only applies to learning, not transfer, but learning is an important antecedent of transfer. Transfer is defined as new learning applied to the job, and Blume et al (2010) found that learning outcomes including post-training self-efficacy and post-training knowledge had small to moderate effects on transfer, after SS/ SMC bias was controlled for. Therefore the model explains the first step of transfer- learning- but not the whole transfer process.



Figure 7: 'Ripples' model of adult learning: adapted from Race (2010)

Figure 7 shows Race's "ripples" model, with the factors in the transfer literature that may correspond to each factor in the model in brackets beside them.

When discussing individual characteristics, the transfer literature appears to focus on determining the profile of the "ideal" delegate in terms of potential to transfer, while the literature on adult education focuses on adapting training and learning opportunities to meet learners' needs. In terms of practical relevance in health and social care, due to the numerous problems with the concept of either moulding or selecting learners on the basis of ability to attend training, and the wide breadth of staff prior learning and experience (from unqualified agency staff to doctors) the latter option of adapting training to fit learners would appear to be a more appropriate strategy.



Finally, Blume, Ford et al (2010)'s study found that after SS/ SMC bias is controlled for there were a surprisingly limited number of strong predictor relationships with transfer. Type of training also influenced the variables that affected transfer. The results of this literature review, illustrated diagrammatically in Figure 8 should be interpreted with Blume et al's findings in mind, as many of the studies included will have an element of SS/ SCM measurement bias to them.

Figure 8 shows that the policy makers' assumptions about transfer illustrated in Figure 3 are simplistic. The relationship between trainers delivering programmes and delegates transferring their training to practice is complex, and depends on numerous factors. Figure 8 shows how some of the categories of factors that influence transfer are related; for example the transfer climate affects training motivation, which affects transfer. Context tends to moderate the causal relationships. The mechanisms that affect transfer and the contexts that facilitate them will be investigated in terms of health and social care training in the following section, which will result in an updated version of the programme theory outlining the context, mechanism and outcome components.

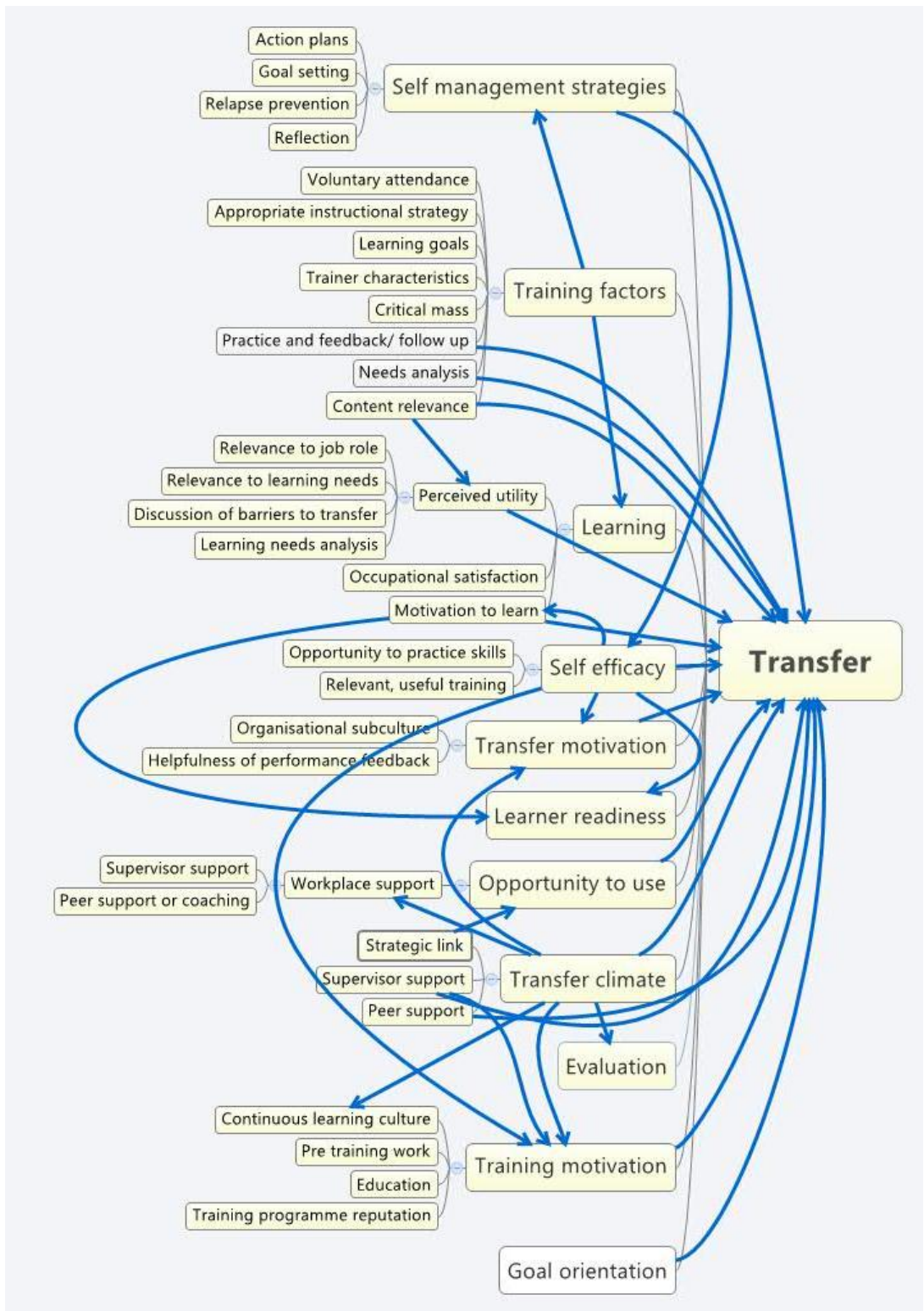


Figure 8: Diagram illustrating some of the relationships between training transfer antecedents, identified in the systematic literature review



## Chapter 8 Search 2: health and social care transfer literature

### 8.1 Using the implementation chain to structure the evidence

Pawson outlines,

“Programs work (have successful ‘outcomes’) only in so far as they introduce the appropriate ideas and opportunities (‘mechanisms’) to groups in the appropriate social and cultural conditions (‘contexts’). All else in realistic evaluation follows from such explanatory propositions.” (57)(Pawson & Tilley, 1997)

In this section, the findings concerning context, mechanism and action which contribute to successful training outcomes in health and social care will be outlined using the structure of the implementation chain outlined in Figure 3. The evidence for and against each ‘link’ in the implementation chain, and the assumptions implicit in each link, are discussed below.

#### 8.1.1 Problem identified: adult abuse is occurring on a large scale. Safeguarding adults training is mandated in policy

***Assumption 1: Staff lack of knowledge causes, at least in part, perpetration or continuation of abuse.***

Staff education and development is one of the most common responses to the challenges of care, and a method to improve the confidence and competence of the workforce (Stolee *et al.*, 2005). The underlying programme theory in policy regarding safeguarding adults training assumes that a causal factor in the perpetration or continuation of abuse is the lack of staff knowledge about how to manage safeguarding situations. Therefore imparting knowledge to staff should help to prevent abuse. Some authors have explained the mechanism relating to different subjects; for example the stated mechanism of action for providing training on end of life care was

that increasing staff knowledge of care for the dying and how to handle this professionally would help staff deal with a fear of death, and consequently reduce their anxiety and depression (Thulesius et al., 2002). However not all rationales for training are so articulate; Meyer comments on the current state of UK training, citing a lack of evidence that training is a useful or effective way to change practice, and noting that

“a good deal of faith seems to be placed in training, based on the assumption that it will deliver some form of benefit to an organisation” (Meyer *et al.*, 2007, :310)

In light of search 2, we see that this notion overlooks the fact that that some staff may lack the personal values or skills to do their job well, regardless of how much training they attend (Baker, Fox & Albin, 1995). Despite this, the same programme theory is used in the training evaluations that exist in the health and social care training evaluation literature (Bayley *et al.*, 2007; Ford, Bammer & Becker, 2009; Gauntlett, 2005; Heaven, Clegg & Maguire, 2006).

Furthermore, the notion of learning may be overshadowed by a requirement to provide and attend training. Some authors have argued that the conceptual framework held by social service departments regarding what makes training effective needs to be changed, and moved away from “number crunching” (Clarke, 2002, :158). Such a number crunching culture implies that attending, rather than learning and improving practice is the priority. This may result in a lack of attention being given to the quality of training; worryingly, Killick and Allen point out that there is an “alarming lack of

research” on the effectiveness of training risky topics such as procedures for restraint - yet there are a “proliferation” of organisations that provide such training (2005, :325).

Another mechanism, changing attitudes, is not implied in the policy makers’ programme theory, but appears to lead to practice change. The response to challenging behaviour is determined by attributions, as well as knowledge. One study found that different types of challenging behaviour led to different attributions of control, which affected propensity to help (Stanley & Standen, 2000). This indicates that knowledge of how to manage behaviour alone is not sufficient to spur people to engage in helping behaviours; attributions also have an impact. It is possible that this applies to safeguarding adults, especially in terms of institutional abuse where a person might be perceived as ‘difficult’. If ‘difficult’ behaviour is judged to be intentional, helping behaviours may be less forthcoming- which may constitute abuse. Other authors support this idea; Stolee et al (2005) posit that rather than a knowledge gap, an ‘attitude gap’ might hinder changed practice; this is corroborated by a study on the impact of training about alcohol abuse in older adults (Peressini & McDonald, 1998). Another study into training on the sexuality of older people stated that negative attitudes towards the topic are contributed to by lack of knowledge, so reasoned that educating people about it would lead to an improvement of attitude and encouragement of sexual expression. The evaluation found that attitudes did improve post training; but there was little evidence to suggest that staff would take action to help residents with their sexuality needs (Walker & Harrington, 2002). Videos and discussion were included in the programme, but no transfer supports are mentioned. It

appears training can both affect knowledge and attitudes; but this does not always lead to changed practice.

Another study found that a deficit in communication and team work might have been responsible for poor performance in a nursing home (Morgan *et al.*, 2007). The programme, which was initially aimed only at nursing assistants, was expanded to include a supervision module for nurses to address a breakdown in relations between levels of staff, described as “strained if not adversarial” (ibid: 64). Supervisors cited a lack of knowledge and a need for continuing professional development to improve their supervisory skills. This shows the merit of looking at each individual situation to determine the main underlying causes of practice deficit, rather than assuming that topic related knowledge gap is the universal issue.

A study examining child protection training outlined that multiagency training is important to achieve a shared understanding of procedures, so that staff from all agencies respond to guidance in a uniform way. Training is seen as a way to establish an agreed set of principles across differing sets of professional values and principles (Buckley, 2000). This introduces a new element of shared learning; rather than just being about improving individual knowledge, it encompasses the work of a team and the need for other people to be working in the same way.

These findings imply that as well as a knowledge gap, a skills gap, attitude gap, and interpersonal or team issues can be the source of a performance deficit. Part of the mechanism of health and social care training aims to address these deficits, to provide knowledge or skills, change attitudes or address interpersonal issues.

However in some cases, training has no impact on performance. Heaven et al (2006) offer an explanation for this, in that there is a gap between competence (what a person is able to do) and performance (what a person actually does). It is possible that training only addresses the competence issue, but not the performance issue, meaning that addressing the 'knowledge gap' or other deficit is only one element of changing practice.

The findings of a national evaluation of a safeguarding adults training programme in Scotland (Dementia Services Development Centre, 2010) corroborates this idea. The training in Scotland was devised in response to the Adult Support and Protection (Scotland) Act 2007. The intervention objective is not explicitly stated in the report, but appears to be to raise awareness (i.e. increase knowledge) of the Act, as this was the main outcome reported (knowledge of the act increased by 20%, and 'cascading' of information was reported). However there was limited behaviour change- this is reflected in the finding that there was a lack of experience in using the Act in "real situations" (Dementia Services Development Centre, 2010, :19). Furthermore, only half of respondents felt confident that they or their colleagues could implement the Act if necessary, and felt that in any case it was down to "the strict policies that are in place rather than any training or lack of it" (ibid: 19).

These findings show that the initial 'link' in the implementation chain is more complex than a knowledge gap, and there may be other causes or contributors to abusive practice. These may need to be addressed in different ways. Staff may have a fundamental lack of ability that no amount of training could address; this should be addressed through good recruitment and selection strategies. An 'attitude gap', or, as



outlined in section 2.4, negative attitudes towards particular groups of people who use services may contribute towards abusive practice. Structural, cultural or interpersonal issues between staff can contribute. Staff may already possess the knowledge, but be unable to translate that knowledge into changed practice for a variety of reasons. Furthermore, the merits of addressing an individual knowledge gap, when addressing an issue which requires team work also needs consideration. While learning is logically a necessary stage in the transfer process (Meyer *et al.*, 2007), training on its own may not be an effective solution to such a wide ranging set of contributors to abusive practice.

***Assumption 2: mandating training will ensure compliance and practice improvement***

There is limited evidence of the effectiveness of mandatory training, and the studies evaluating training included here described voluntary attendance to training programmes. However the conflict between mandatory training and adult learning theory has been discussed in relation to NHS training (Mythen & Gidman, 2011). The authors argue that mandating training is necessary to ensure standardised and safe practice in healthcare, but also negates the role of the adult learner in choosing what to learn; instead, they are told what to learn. Horwath and Morrison (1999) point out that there is a tension between requirements of organisations and the needs of individuals in terms of learning; the question is whether mandatory training can still lead to positive outcomes if it undermines learners' control and autonomy. Mythen and Gidman, along with proponents of adult learning theory, suggest that intrinsic motivation to attend is important for adult learners (Knowles, 1990) and forcing people to attend training that they perceive as irrelevant may cause resentment and

undermine motivation to learn. This implies that mandating training without concurrent strategies to boost intrinsic motivation to attend may lead to compliance in attending- but not learning or practice change.

Collins (2008) found that, in the context of changing the approach of managers to youth services, oversaturation of mandatory training was a barrier to change. This implies that mandating too many topics can have a detrimental effect, and a clear training strategy should prioritise particular subjects for the year to prevent training fatigue.

However the label of 'mandatory' does not appear to consistently result in all staff being trained. A study carried out in Cornwall, which works under English policy and so mandates training, found that of 647 respondents from statutory (including police and NHS) and independent providers, only 217 (34%) had attended some form of safeguarding adults training (Pike *et al.*, 2011). While the training may have at that time been more 'mandatory' for some agencies than others, the fact that 66% of surveyed staff had not attended any sort of training implies that the term 'mandatory' is not being implemented as such- although there is an issue of training capacity to consider. For mandatory training to be implemented, training providers need to have the resources to offer training to all staff who need it.

The evaluation of safeguarding adults training in Scotland (Dementia Services Development Centre, 2010), was not mandated by government on the provision that providers attended voluntarily; take up has been over 90% (Macaskill, 2011). While achieving high compliance rates, the course did not result in extensive practice change.

It appears that 'compliance' in attending is not, of itself, enough to ensure the ultimate objective of training; changed practice and improved services.

### 8.1.2 Regional training teams devise training programmes

***Assumption 1: adhering to the principles of adult learning causes knowledge, skill and confidence gain, and attitude change.***

The assumptions of adult learning are outlined below:

- 1) Adults need to understand why they need to know something before they start learning
- 2) Adults have a self-concept of being responsible for their own decisions and lives, and a need that self-direction to be recognised.
- 3) Learners' past experience affects learning, and requires acknowledgement as well as individualised teaching and learning strategies.
- 4) Adults learn best when the learning has immediate value (learner readiness)
- 5) Learning orientation needs to be task or problem centred, to help learners perform or manage better.
- 6) Internal or intrinsic motivation is more important for adult learning than external motivation.

(Knowles, 1990)

Concerning point 1), none of the evidence located in search 2 addressed the issue of whether the learners understood why they needed to know something before embarking on training. It is possible that because the learning is work based, it is assumed that the reason for attending is obvious to people. Structures such as supervision have the potential to be used to explore and discuss work related learning needs, but it is unclear whether they are consistently used in the sector.

A collaborative approach, where a 'care home support team' supported staff and their practice was pivotal to the success of an intervention. The support team facilitated practically relevant interactive sessions, and the adult learning-centred approach led to improved teamwork and increased confidence and competence (Lawrence and Banerjee, 2010). In another study, a multiagency team worked in an advisory and consultative capacity to address staff values and attitudes towards communication before moving on to problem solving, ideas and activities- this led to positive outcomes (Dobson, Upadhyaya & Stanley, 2002). Making training design a collaborative process between staff, commissioners of training and training providers can maximise the relevance of training, which aids learning and transfer (Bibus & Rooney, 1995; Meyer *et al.*, 2007).

2 of the principles of adult learning concern task or problem centred learning, which will help learners to perform better, and that learning should have immediate value. Numerous studies have corroborated the importance of this in relation to transfer and its antecedents. Training should be realistic, attainable and locally relevant, incorporating practice and opportunity to implement their skills (Meyer *et al.*, 2007); demonstrably practical and efficacious (Stolee *et al.*, 2005) and include theoretical input, practical tasks (Bryan *et al.*, 2002), and opportunity to practice the skills in a safe environment (Killick, 2005). Relevance appears to be important in the programme theory.

Individualised teaching and learning strategies that acknowledge past experience are an important component of adult learning. Taking nursing assistants' learning needs into account by delivering training to learners in their workplace, in work time, at their

education level, and among their colleagues proved effective, combined with other factors that took account of training transfer principles (Morgan *et al.*, 2007). A learner centred approach was effective for end of life care training (Thulesius *et al.*, 2002) and in a Certificate in Empowering Practice, delivered to care workers from learning disability services (Miers *et al.*, 2005). The intervention also focussed on developing metacognitive control in their students (awareness and control of their own learning strategies) as did another successful intervention on communication (Dobson, Upadhyaya & Stanley, 2002). Other successful interventions attribute their success to a focus on sharing experience and active participation (Stolee *et al.*, 2009) and the use of an approach that was respectful of the good work that youth work staff were already carrying out which made the training a positive rather than potentially threatening experience (Collins, 2008). The interactive nature of training may be important to learning (Richardson, Kitchen & Livingston, 2002) and the development of confidence in managing adult abuse (Dementia Services Development Centre, 2010).

Targeting interventions to take account of baseline knowledge of adult abuse management is important for learning, an antecedent of transfer (Richardson, Kitchen & Livingston, 2002). The national safeguarding adults training programme provided in Scotland makes no mention of taking account of prior experience (Dementia Services Development Centre, 2010); it is presumably difficult to tailor programmes to individual learners when they are delivered on a national scale.

As identified in the previous chapter, principles of adult learning, such as learner readiness also appear to contribute to transfer. In the context of social care training Antle, Barbee *et al.* (2008) found that learner readiness was a joint predictor of

transfer, along with learning and management support of training, while another study correlated transfer with learner readiness (Antle *et al.*, 2010). Both studies operated in a context of American Child Welfare, analogous to Safeguarding Children in the UK. This corroborates evidence that following the principles of adult learning alone is not sufficient for training to be effective; workplace factors also influence transfer (Heaven, Clegg & Maguire, 2006). However one study found that people who rated themselves lower in learner readiness reported higher levels of transfer (Sullivan *et al.*, 2009). The authors suggested that those who are high in learner readiness perceive that there is always more to learn, so rated their transfer lower. This highlights the difficulties in objectively measuring transfer.

While the principles of adult learning appear important in the mechanism of social care training transfer, there is little evidence to show whether or not they are adhered to in safeguarding adults training practice. The training outlined in Miers *et al.*'s paper took place over a number of weeks, while most safeguarding adults training lasts between the length of a DVD and (around) 6.5 days for assessing and investigation training (Hampshire County Council, 2009). Getting to know learners and their individual needs is challenging if the training takes place over one day, or less, as much training does. The issue of learner readiness is also one that has not been addressed in the context of safeguarding adults training. However the resources needed to ensure that the principles are adhered to should be weighed against the economic and social consequences of training that does not impact on practice.

***Assumption 2: adhering to the principles of training transfer causes knowledge, skill and confidence gain and attitude change, and transfer***

The findings of the preceding chapter clearly indicate that the inclusion of transfer structures positively influences transfer outcomes. However policy makers presumably either are unaware of the training transfer literature (no reference is made to it in policy), or assume that training providers and attendees take account of it in their practice. The main principles of transfer from search 1 comprised issues including promoting training motivation, having a positive transfer climate, improving self-efficacy, providing relevant and useful information, having strategic linkage with organisational goals, and providing support and follow up.

The principles are also important in social care; multiple strategies which incorporate transfer- supportive structures after the training event should be included in training design (Stolee *et al.*, 2009). As highlighted in the previous chapter, the credibility of trainers in health and social care is important (Collins, 2008; Gauntlett, 2005). There is evidence that follow up acted as the mechanism prompting transfer in the context of management of challenging behaviour training (Killick, 2005) and 'feeding skills' training (Chang & Lin, 2005). Planned follow up, discussion of progress, review or evaluation sessions may trigger motivation to act in health and social care staff, leading to transfer of skills to practice (Chang & Lin, 2005; Eisses *et al.*, 2005; Killick, 2005). However, Stolee *et al* (2005) point out that systemic and organisational factors are not usually accounted for in social care training programmes, so staff may not be supported to transfer.

Spaced training, an effective transfer support in other sectors (Liebermann & Hoffmann, 2008) also contributed to the success of a communication training programme, combined with other transfer supports of discussion of video recordings of staff- service user interactions, feedback and group participation (Dobson, Upadhyaya & Stanley, 2002). The authors argue the 'drip drip' of continuous training and viewing and discussing each other's videos was effective. However, another study found that a spaced intervention was no more effective than a 4 day massed training course; the authors suggested that opportunity for reflection rather than spaced training acted as the mechanism for learning and transfer (Johnsson, Carlsson & Lagerström, 2002). The format of training should take the needs of the organisation (e.g. arranging staff cover) (ibid) into consideration; another spaced training evaluation found that junior staff attended fewer hours which may imply problems of release from work (Thulesius *et al.*, 2002). These studies show that numerous transfer strategies should be considered at the design stage of training, their appropriateness assessed, and organisational support secured.

However social care staff do not always use the transfer supports designed into training. One programme included 'train the trainer' modules, although at follow up, staff said they needed a 'refresher' course; this implies the train the trainer element was not used (Killick, 2005). Another study found that compliance with the resources on offer was low. However, there was no correlation between compliance and outcome of the intervention (Bennett *et al.*, 2007). This could mean that the intervention was ineffective, or that, because of low compliance, other factors such as personal characteristics of delegates had more of an impact. This exposes an



important flaw in the programme theory- lack of compliance. Even if adult learning and transfer supportive strategies are designed into training programmes, people may not use them. This lack of compliance with transfer structures presents a problem to the policy makers' programme theory. Contextual features such as the transfer climate may explain this lack of use of a mechanism.

Compliance may be secured by agreeing post program supports with management in advance of training; this was identified as a critical factor in the success of one intervention (Stolee *et al.*, 2009). Conversely, a study of management training highlighted a lack of transfer supports as a potential flaw in the training design (Sharples *et al.*, 2003).

Supervisor and peer support was another transfer consideration highlighted in search 1 which, again, has been supported by social care based studies (Leung & Cheung, 1998). Supervisors can also provide delegates with opportunities to use their new learning (Meyer *et al.*, 2007). One study introduced a supervision module for nurses who supervised nursing assistants attending a training course which was highlighted as a crucial factor to transfer (Morgan *et al.*, 2007), and relates to the notion of supervisors as 'transfer agents' highlighted in search 1. The programme also required nursing homes to commit to financially reward nursing assistants who completed the programme, and expected sign up from the home, the individual nursing assistant and the program staff. This arguably contributed to the perception of valuing training. The programme had positive outcomes, in terms of improved confidence, job satisfaction and pride in their work, better team work; supervisors became more proactive than reactive. They also felt rewarded by the monetary raises following completion of the

training, and morale improved. An additional transfer related support was having an onsite trainer, meaning nursing assistants were supported to use their learning in their work. This is an approach recommended by other authors, as a way to provide 'in the moment' teaching- this has direct practical relevance and so is easy to transfer (Stolee *et al.*, 2005). This study is illustrative of the multiple transfer strategies often used in social care to facilitate transfer.

Having a practical tool to learn about on training, and then use in the workplace has provided some positive outcomes (Eisses *et al.*, 2005; Tsiantis *et al.*, 2004). However Tsiantis *et al.* found that a third of respondents found obstacles to using the checklist in their job, including work overload, lack of further guidance, and problems communicating concerns from the findings of the instrument with colleagues who had not attended the training. Although the training led to changed attitudes and knowledge, practice was not changed; again, this raises the issue of ongoing support. Other studies have shown that tools, such as action plans, when combined with follow up can lead to transfer (Bibus & Rooney, 1995). Participants felt that follow up showed the projects' continuing interest in them and the value of the training on the job. The study also entailed parallel training of supervisors; this mechanism was not explored in as much depth; one possibility is that it allowed for further support of the participants, as their managers had a good understanding of what they were meant to be doing.

Workplace support can also be gained from providing cohort or cascade training (Morgan *et al.*, 2007) which can promote clear communication and shared knowledge (Stolee *et al.*, 2005) or sharing learning at team away days (Sharples *et al.*, 2003). Another study found evidence of training being cascaded, as knowledge increased in

control groups as well as those who received training. This supports the notion that the culture of an organisation influences staff strategies in managing behaviour, as training some staff impacted on the wider group (Killick, 2005).

However, while the literature shows that such transfer supports are important in social care training as well as general training, there is little evidence to say whether safeguarding adults training generally designs in such supports. Furthermore numerous studies with positive outcomes combined several transfer supports, and it is possible that this is necessary to achieve positive outcomes from training in health and social care. The Provider Manager training in Cornwall has a half day follow up one month after the initial day training, but the Human Rights workshop comprises a single day with no follow up. Both courses include a component of preparation (see Appendix Q and P), and both courses emphasise the practical implications of the learning. The narrative analysis will address the issue of whether these transfer structures were effective.

***Assumption 3: when the workforce understand that training is for the purpose of addressing a performance deficit, practice change results***

Pawson and Tilley (1997) highlight the psychological nature of programs as being about people and their backgrounds, experiences, loyalties, expectations, history and future, and go as far as to say “a program *is* its personnel, its place, its past and its prospects” (pg. 65). They explain how social mechanisms impact on individual behaviours- consequently, whether training transfer occurs is of course down to the person attending training, but is also influenced by the social structures around them which may motivate, or demotivate them to do so. For training to work, it can be argued that

delegates, their managers and peers, and the trainers need to have a shared idea of what the training is meant to achieve and how it will achieve it. Unfortunately this topic is not often commented on in the literature. Reactions, learning and behaviour are measured; understanding of the purpose of training is generally not.

However some studies have addressed the psychological element of behaviour change (Antle *et al.*, 2010). Antle *et al* detail the steps that were taken when designing a successful training programme about a controversial topic, including careful consideration of the framing of training, and anticipating and addressing the challenges that delegates might face when trying to implement the learning. The training resulted in attitude change, and self-reported transfer. In this case the mechanism was both that delegates understood what the training was meant to achieve, and trainers communicated an understanding of the difficulties of achieving this in practice.

Another study investigated the workplace factors that have the biggest influence on training transfer in long term care, using a Delphi study. Learners' belief in the practicality of the training was rated the third most important factor, and knowing that change is supported was also rated important (Stolee *et al.*, 2005). Again, this supports the notion that training must be framed in an appropriate way in order to ensure transfer.

### 8.1.3 Trainers deliver programmes to health and social care staff

***Assumption 1: conducting a learning needs analysis causes the right people to attend***

The “right” people here are considered to be people who have a learning need concerning safeguarding adults that training could address; they necessarily should also have a job that has some connection to either working or volunteering with vulnerable adults.

There is some evidence that, where training is voluntary, people with more knowledge of the topic (and perhaps correspondingly more interest in it) are more likely to attend (Peressini & McDonald, 1998). Antle et al (2010) found that the control group had significantly lower knowledge of the topic of interest than the experimental group, which suggests the experimental group have more interest in, and higher motivation towards the topic. A study of UK nurses speculated that non-responders to the invitation to participate in communication skills training may have been less able in this area and less psychologically minded, while participants may have been more aware of communication deficits, and more motivated to improve their skills (Heaven, Clegg & Maguire, 2006). For topics such as safeguarding, which all staff need to implement, mandating training may be one mechanism to ensure all staff attend. Another study of UK nurses found that some interviewees had attended training for which they could see no relevance, and without the chance to practice their new learning, the skills had been lost. This implies that when the ‘wrong’ people attend programmes, motivation to transfer can be affected. Conversely, learning contracts (Meyer *et al.*, 2007), choosing staff with the right skills to attend training (Stolee *et al.*, 2009) and creating a culture that values training could facilitate the right people attending, and transfer (Stolee *et al.*, 2005).

Practical challenges, such as communication, notice periods for training, a shortfall in funds to meet all learning needs, and ability to cover staff (Sharples *et al.*, 2003) and pressure to fill courses leading to inappropriate people attending (Meyer *et al.*, 2007) have been highlighted as barriers to the right people attending training. This implies that contextual features such as a positive transfer climate and adequate resources are necessary to ensure the right people attend.

As mentioned above, the 'right' people are people who would find the training useful, relevant and timely for their work performance. Learning needs analysis can help to make training useful; this may explain the findings linking the process with transfer in search 1. It may also prevent people from signing up to training which they do not find relevant; one study found that only 41% of voluntary attendees thought the training was relevant to their work (Peressini & McDonald, 1998). Other pre-training analyses that may aid social care transfer include discussing with management which model of practice would be most appropriate (Killick, 2005), using initial assessment to develop an educational programme (Deakin & Littley, 2001), and a district wide training needs analysis (Dobson, Upadhyaya & Stanley, 2002). Learning needs analysis appears to be a mechanism that supports transfer, through ensuring that the right people attend training.

#### 8.1.4 Delegates transfer learning to practice

***Assumption 1: when training transfer and safeguarding adults support mechanisms are in place, training transfer results***

As well as training transfer needing to be planned into training design, the systematic literature review showed that structural supports must also exist in the workplace in

order to ensure that transfer occurs. There is no mention of the importance of mechanisms to support training transfer in UK safeguarding adults policy, despite the abundance of literature that shows that transfer is an important consideration when providing training programmes. This implies an assumption on the part of the policymakers that transfer structures exist, and are being utilised in the sector. There is much evidence to suggest that such structures are important, even though they are not consistently used in the sector.

The effect of support has been tested experimentally, and found to lead to a significantly higher rate of transfer (Antle et al., 2009). The targeted, skills based nature of the training, as well as the fact the training was relevant as it concerned an often used skill, may also have affected transfer. Delegates who rated supervisor and team support higher also rated training more useful, demonstrating the importance of organisational support of learning to promote positive attitudes to training and its implementation (Sullivan *et al.*, 2009). Opportunity to use critical care skills was related to transfer for UK nurses, as were supports including time spent with competency assessors, supernumerary time, and a positive and supportive environment (Meyer *et al.*, 2007). Conversely, financial pressures which restricted these opportunities, or lack of supervision or guidance, had a negative effect on transfer. Meyer concluded that,

“any investment made in the training intervention itself is lost if course attendees are not supported to share their skills and embed new knowledge”  
(ibid: 314)

Extra supports, such as action plans, supervisor involvement in training and action planning, and follow up evaluation have helped to ensure that new learning is embedded into practice (Bibus & Rooney, 1995). However, the same study found that participants felt unable to influence agency policy, and felt that using their learning was constrained by budget cuts, increases in demand for services, policy changes and reorganisation. Again, this highlights the importance of a supportive work environment, where training is aligned to organisational policy. One study found that while the competence (in terms of knowledge and communication skills) of nurses in the experimental and control groups improved, only nurses in the experimental group who received clinical supervision as well as training actually transferred their skills to practice (Heaven, Clegg & Maguire, 2006). Clinical supervision acted as a transfer support mechanism, possibly through providing feedback and encouragement, which may have increased nurses' communication skills related self-efficacy.

Management buy in and support of programmes has been highlighted by some authors as a major factor in the success of a programme (Lawrence and Banerjee, 2010; Morgan *et al.*, 2007; Stolee *et al.*, 2009). Other interventions (Antle *et al.*, 2009; Antle, Barbee & van Zyl, 2008; Antle *et al.*, 2010) have encouraged supervisors to attend training with their staff; presumably so they can offer support post training. Conversely, some interventions which have not successfully maintained change suggest using training booster strategies (Gates, Fitzwater & Succop, 2005) that have potential management involvement implications. Morgan *et al.* (2007) found that formal arrangements, including contractual commitments to training and financial incentives contributed to the success of the programme, as it made it more difficult to



reschedule or deprioritise. Management support was rated the most important workplace factor in terms of impact on training effectiveness in a Delphi study (Stolee *et al.*, 2005). Other factors included sufficient resources, the integration of learning into ongoing practice, valuing staff, on the job reinforcement of learning, knowing that change of practice is supported, and seeing benefits of new approaches. These factors highlight the importance of considering the workplace environment- or having a focus on the organisation as well as the individual (Johnsson, Carlsson & Lagerström, 2002) - in the training programme theory.

Furthermore, post training supports have been shown to be ineffective without management support (Bennett *et al.*, 2007). A lack of reinforcing structures was cited as responsible for a lack of action plan completion at 6 month follow up of a safeguarding children training course (Buckley, 2000). It seems that such post training activities are valuable when they include the time and support to carry them out.

As mentioned earlier, very little evidence exists relating to safeguarding adults training effectiveness specifically. One paper, a cross sectional survey of safeguarding adults knowledge, confidence and training attended in the health and social care sector in Cornwall conducted in 2009 found that confidence, which was affected by workplace factors, appeared to be an important factor linking training and action (Pike *et al.*, 2011). The model illustrated in Figure 9 was posited, based on correlations obtained from the survey data. This implies a theory of transfer that is corroborated by the preceding literature; that training, in the context of a supportive workplace, improves confidence in actions by increasing knowledge about how to undertake them, leading to the outcome of increased likelihood that those actions will be taken.

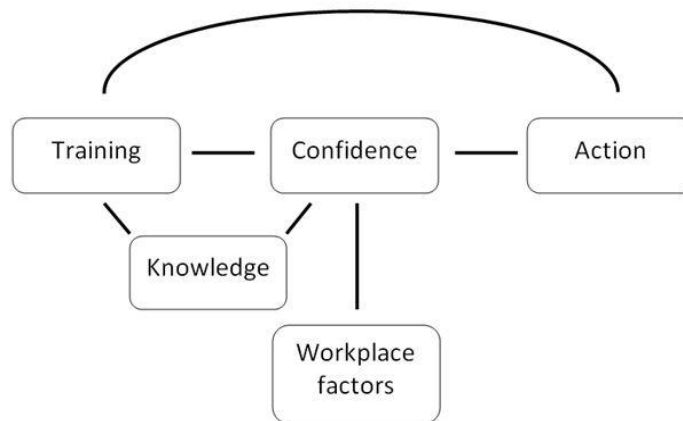


Figure 9: Model of the relationship between training, knowledge, confidence and action. From Pike et al (2011: 269)

However much evidence, while agreeing that support mechanisms are necessary to maximise transfer, points out that they are often lacking in the health and social care sector; and where they are lacking, transfer does not occur. Clarke (2002) concluded that a case management skills intervention was not effective due to a lack of organisational cues to training transfer. Barriers to transfer included heavy workloads, time pressures, lack of reinforcement of training, an absence of feedback on performance and a perception of training as for personal, rather than organisational development. Two important factors, opportunity to use and support were lacking. The perception of training is arguably the third factor, as if there are no cues to transfer, workers will not feel as if transfer is expected of them. Another study reported that some interventions were less successful due to breakdown in agreement about staff attendance, difficulty sustaining commitment to attend, attrition and holiday disruption; this occurred despite high levels of commitment from organisations initially (Dobson, Upadhyaya & Stanley, 2002). Successful interventions were those where a training contract was agreed with staff and managers, and adhered to. Again this implies that an important part of the mechanism of action is agreement of transfer

supports from the outset. This may also explain the findings of a study of training on alcohol abuse in older people, where intentions to use material were greater than actual use; participants talked about a lack of policy and structures to support change which meant the responsibility for transfer lay solely with the individual (Peressini & McDonald, 1998). Similarly a nursing home based oral hygiene intervention (Frenkel, Harvey & Needs, 2002) had some success, measured by plaque reduction, but also highlighted workplace factors that inhibited transfer. Workplace factors were also identified as limiting transfer of a teamwork enhancement intervention in healthcare (Bayley *et al.*, 2007), and lack of supervision and post training support hindered the consolidation and transfer of management skills from course to practice (Sharples *et al.*, 2003).

Another study found that homes that had formally recognised the efforts of staff, provided designated time and resources to implement the learning, and provided networking opportunities with other trained staff from other homes had the best outcomes. Successful homes also had several trained staff (critical mass), and used coaching, mentorship and consultation support as offered. A lack of success was attributed, by homes where the intervention had not been effective, to lack of time, workload and support. In these homes, staff had generally attended the training but not engaged with other post course support activities (Stolee *et al.*, 2009). Having a 'critical mass' of people attend a course from one workplace was perceived to be the most significant facilitator of transfer of a mental health qualification (Gauntlett, 2005).

In a review of the role of education and training in achieving change in care homes, Nolan, Davies et al (2008) concluded that,

“what is quite clear is that education and training are not a 'quick fix' and need to be embedded within an organisational culture that encourages and supports change. This is a long term agenda” (ibid: 427)

That receptiveness to change is enhanced through supportive transfer and human resources structures, which have the potential to send a positive message to delegates about the transfer climate, which encourages them to apply their learning. The authors go on to state how management support, regular supervision, feedback and mentorship are essential, as are identifying and circumventing potential barriers to applying the learning. The effectiveness of this approach has been corroborated by many of the studies mentioned above (e.g. Lawrence and Banerjee, 2010).

One study found that providing training without role support actually had a detrimental effect on nurses' therapeutic attitudes towards patients who use illicit drugs (Ford, Bammer & Becker, 2009). Workplace drug and alcohol education was only effective once a good level of role support for the topic was also observed. The authors suggest that the mechanism of providing information, in the context of little role support, fails to improve outcomes because it merely heightens nurses' awareness of their skills deficits or lack of expertise, lowering their confidence in their ability and leading to disengagement with the patient. When role support is provided, confidence increases and practice is improved.

In summary, there is much evidence that supportive transfer structures are necessary for health and social care based training to lead to transfer, and also that such

structures do not always exist; where they do not exist, transfer suffers. This implies that a supportive work environment that offers opportunity to use training, and a positive transfer climate is an important contextual feature in health and social care training transfer. However, again there is little evidence specifically relating to safeguarding adults training.

## 8.2 Realist synthesis

The secondary evidence outlined above was used to revise the policy makers' programme theory of safeguarding adults training, shown in Figure 3. The resulted in an amended programme theory of health and social care training, based on both policy and evidence. A realist synthesis is explanatory, so it does not provide a verdict on what works or doesn't, but instead offers observations about what worked, how and for whom. Therefore the objective is not to say whether training works, but instead identify when it works, and how. By understanding this, the conditions under which training does work can be aspired to in organisations, meaning training is more likely to be effective. The objective, as outlined by Pawson, is to

“produce a model that will be helpful in implementing and targeting such programmes and, above all, in creating realistic expectations about what can be achieved” (Pawson, 2004).

The systematic literature review in Chapter 7 highlighted a number of factors which may be important in supporting the transfer of learning to practice. Numerous factors are contentious; they have been found to exert influence in some studies, but not others. The discrepancies in findings, viewed through the technique of realist synthesis, can be explained by context. The realist synthesis approach to the second

search analysed the data differently, by looking for the mechanisms that underlie transfer and the contexts that enable those mechanisms to successfully work. This was framed using the structure of the implementation chain of safeguarding adults training; each stage of the chain, and its assumptions, was investigated and compared to the existing literature on social care training transfer. Many of the factors noted in the general literature were also found to be important to social care transfer. A refined version of the programme theory is illustrated in Figure 10. The solid arrows represent causal relationships in the model. Moderators of specific causal relationships are shown on the relevant arrow in purple.

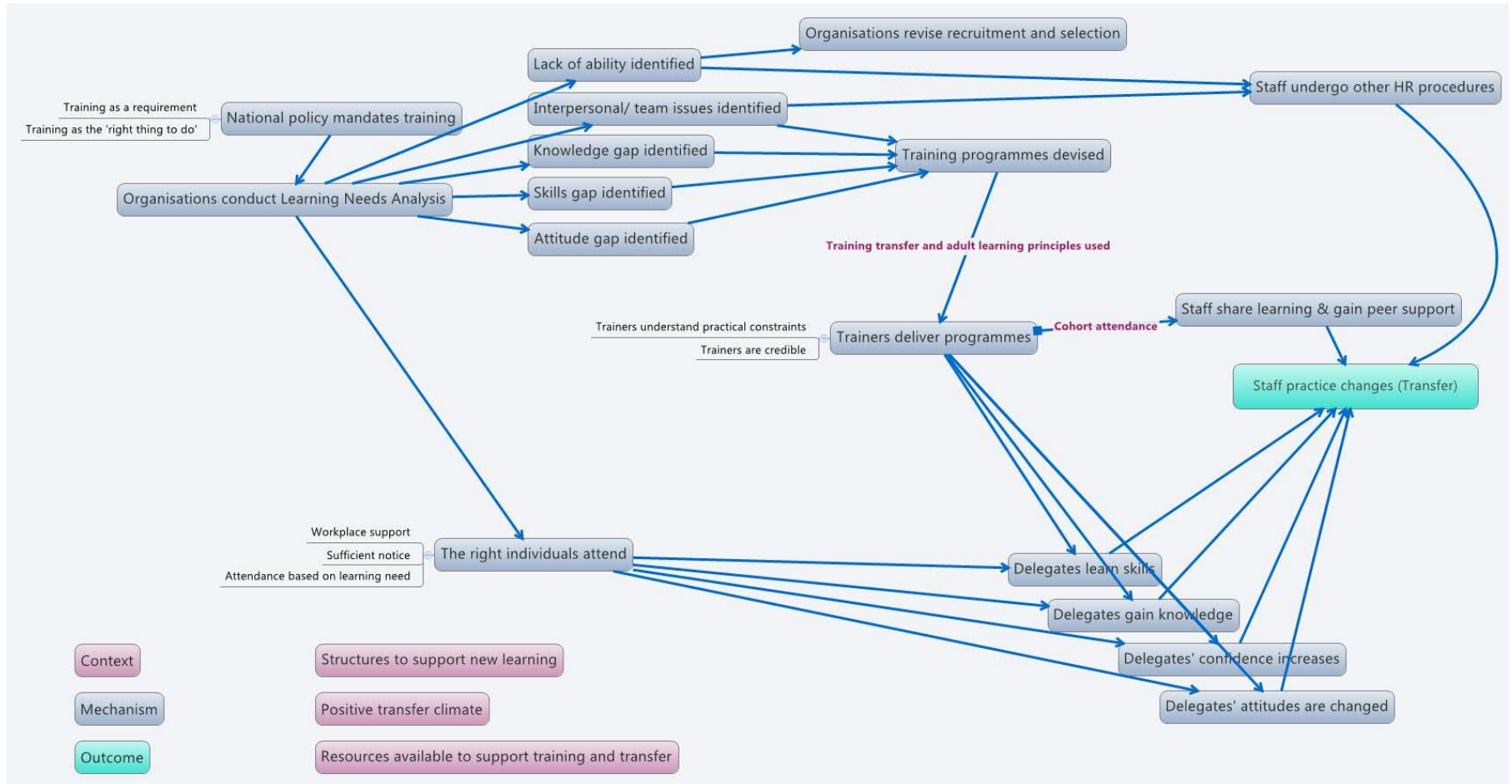


Figure 10: Second iteration of the programme theory, following the realist synthesis. Solid lines represent causal relationships.

The model illustrated in Figure 10 shows the programme theory for the training process generally in health and social care. The next stage of analysis will use the primary research conducted in Cornwall to modify the model, where necessary, so it applies specifically to safeguarding adults training. This will include elaborating on ‘transfer’, to explain in further depth what impact the training has on practice.

A model was constructed using quantitatively measurable elements of the modified programme theory above, combined with findings from the review of the safeguarding adults literature presented in Chapter 3, in order to illustrate the hypotheses that the factorial survey will test.

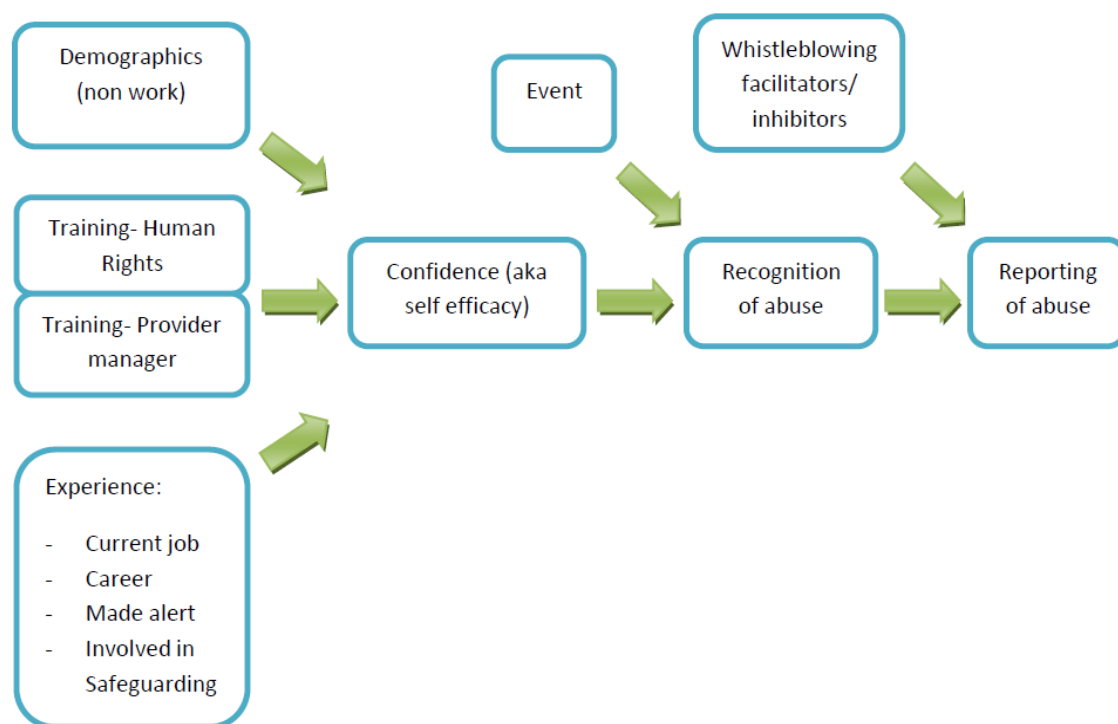


Figure 11: Model of the impact of training, to be tested using the factorial survey method

The causal propositions are listed below, and will be tested using the factorial survey data.

1. Demographic factors influence confidence ratings
2. Training level influences confidence ratings



3. Past experience of safeguarding influences confidence ratings
4. Current job level influences confidence ratings
5. Experience working in the sector influences confidence ratings
6. Experience working in current job influences confidence ratings
7. Confidence influences recognition of abuse
8. Factors in the scenario influence recognition of abuse
9. Recognition of abuse influences reporting of abuse
10. Facilitators and inhibitors of whistleblowing influence reporting of abuse

## **Chapter 9 Results: Factorial survey**

### **9.1 Introduction**

The factorial survey aimed to address the question of what effect training has on the threshold to recognising and reporting abuse. The use of the factorial survey method also addressed the question of which factors within a given scenario affect the rate of recognition and reporting, and how these factors interact with training attended. It provides a quantitative and novel measurement of the impact of training.

176 participants read 6 vignettes each, and responded to the question of whether, on a scale of 1-9, they thought that abuse was occurring, and how likely, on a scale of 1 to 9, they would be to make a safeguarding adults alert. Results are outlined below.

### **9.2 Data distribution.**

Plots of the raw data for the dependent variables recognition, reporting and confidence are below. Scores for baseline vignettes were not included; these tended to be high (49% rated 9/9). Recognition and reporting plots show a negative skew towards higher rating tendencies, with clustering around the higher anchored points (5 and 9). This is problematic because regression analysis assumes normal distribution of data. Field recommends that for large sample sizes (over 200), significance tests of skew and kurtosis should not be used as they are likely to be significant even if not too different from normal. Instead he recommends looking at the shape and value of the skewness and kurtosis statistics (see Table 11) rather than calculating their significance (Field, 2009).

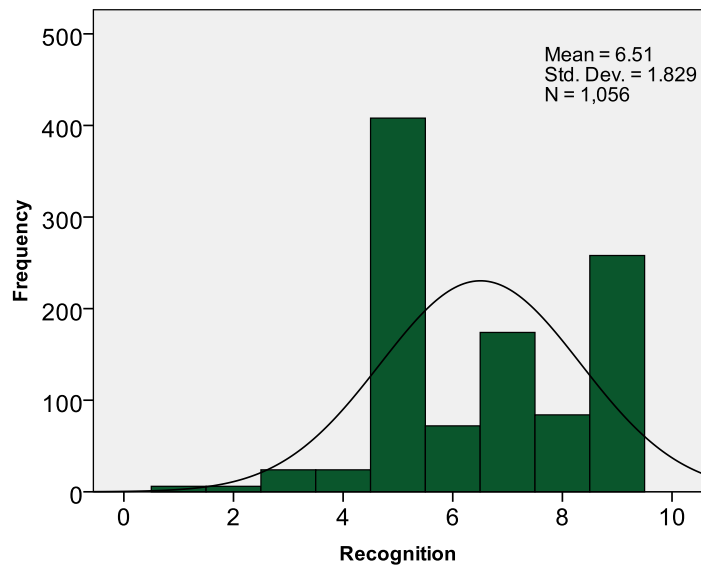


Figure 12: Graph of ratings of recognition of abuse, from 1 (Definitely not abuse) to 9 (Probably is abuse)

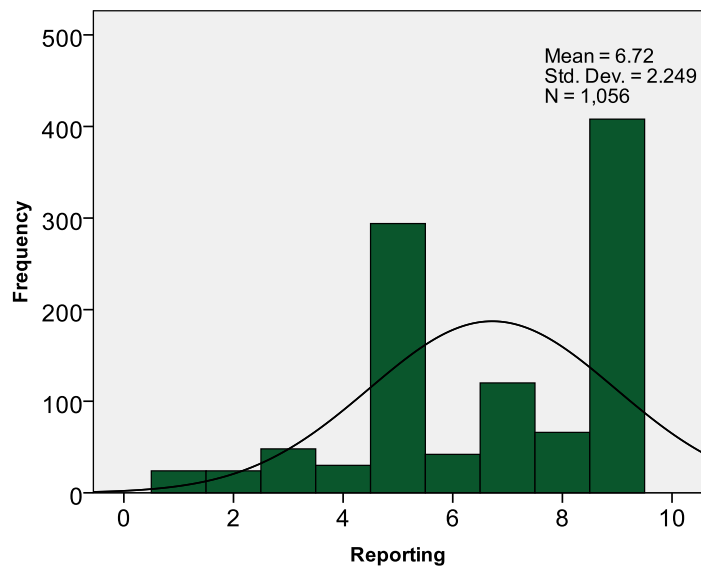


Figure 13: Graph of ratings of reporting of abuse, from 1 (Definitely wouldn't make an alert) to 9 (Definitely would make an alert)

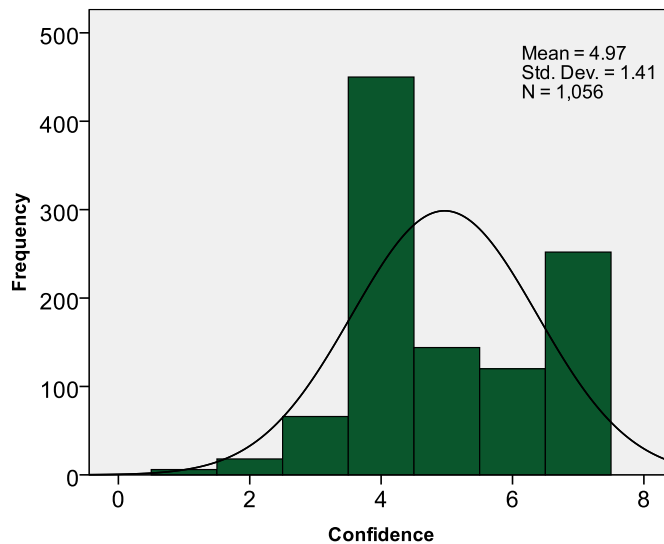


Figure 14: Graph of ratings of confidence, from 1 (Not at all confident) to 7 (Extremely confident)

It was decided to control for individual differences in rating tendencies by transforming the data using average baseline scores (O'Toole, 1999). This was discussed with a statistician, who agreed that such a transformation would be a sensible way to adjust scores to have the same reference point. Because all participants rated the same two baseline vignettes before rating the experimental vignettes, the scores they gave to the baseline indicated whether they had high or low rating tendencies in comparison to each other. The transformation was carried out by calculating the average rating of the two baseline vignettes, then calculating the deviation of each individual's response to the average rating. Deviations for each individual's recognition and reporting rating scores for the two baseline vignettes were averaged to create a deviation score. All subsequent vignette ratings by each individual were then adjusted by adding their score to the deviation score. The resulting plots are shown below.

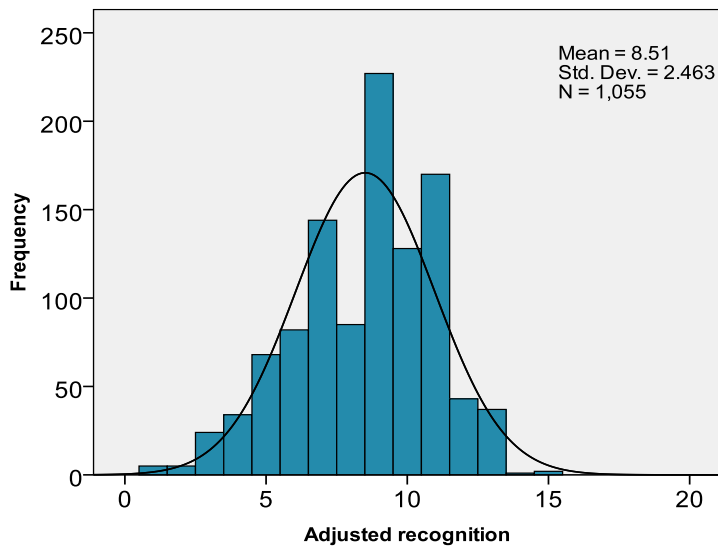


Figure 15: Graph of adjusted ratings of recognition of abuse. Scale extended.

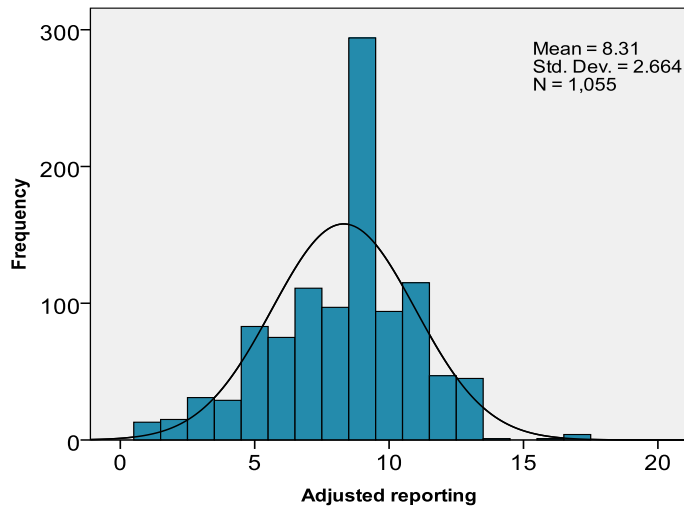


Figure 16: Graph of adjusted ratings of reporting of abuse. Scale extended.

The range of scores increased due to this transformation, but the data were in the main more normally distributed; kurtosis values both improved, as did skew value for reporting, though recognition skew became worse. These adjusted ratings, which have been shifted up 2 points to begin at 1 (rather than -1) were used in the multiple regression.

	Skew	Kurtosis
Recognition (original)	-0.009	-0.871
Recognition (adjusted)	-0.407	-.199
Reporting (original)	-0.555	-0.688
Reporting (adjusted)	-0.350	0.265

Table 11: Skewness and kurtosis statistics for dependent variables.

### 9.3 Data analysis

Ordinary Least Squares regression was used to ascertain the effect of each factor, and demonstrate any intergroup differences.

In order to perform multiple regression, a parametric test, the data must be assumed to be either categorical, interval or ratio. The vignette study used Likert scales as its primary data collection measure (Lauder, Scott & Whyte, 2001; O'Toole *et al.*, 1993; O'Toole *et al.*, 1999; Schwappach & Koeck, 2004). Using Likert scales as interval (as opposed to ordinal) data is commonly practiced (Taylor, 2006), although controversial (Jamieson, 2004). Jamieson argues that to use Likert scales in parametric tests, attention must be paid to the sample size and distribution of the data. The assumption that the distance between each point is equal must also be clearly stated. The distribution of the data was checked (normal distribution is required). Parametric tests favour scales with greater range, so 9 point scales were used. Significance levels of  $p < 0.05$ , and  $R > 0.25$  were applied.

Assumptions which must be met when using ordinary least squares analysis outlined by Field (2009) are listed below.

**Variable type;** predictors must be quantitative or categorical (assumption met) and dependent variables must be quantitative, continuous and unbounded (assumption met).

**Non zero variance of predictors** (assumption met).

**No perfect multicollinearity between predictors;** the factorial survey factors are orthogonal, because they varied independently of each other through random number selection. Other predictor variables relating to the demographics of respondents were mainly categorical so individual pairs of correlations were tested using the Chi Squared test. It was found that all the demographic variables were highly associated (see Appendix S for the correlation matrix). Demographics included age, length of time worked in health or social care, length of time in current job, job title, training attended, education level, whether they had been involved in a safeguarding adult investigation before, and whether they had made an alert before. The variable “Length of time working in health and social care”, converted into a dichotomy of over 5 years vs. less than 5 years was chosen to use as a proxy for all demographic variables. Training was included because it is the subject of investigation, and the variables “Involved” and “Made Alert” were also included, as they represent past experience with safeguarding.

**Predictors are uncorrelated with “external variables”.** The validity of this assumption is unknown.

**Homoscedasticity.** Plots were checked and showed that this assumption was met.

**Independent errors;** this only applies in test- retest situations, so is not applicable here.

**Normally distributed errors;** Histograms showed this assumption was met.

**Independence;** Field states the independence assumption assumes that “all of the values for the outcome variable are independent (in other words, each value of the outcome variable comes from a separate entity)” (2009, :221). Because each person completed 6 vignettes, a test of independence was created by calculating the range of responses from each individual participant (each participant answered 6 vignettes), and then the range of responses from 30 x 6 randomly selected responses across all participants for the 2 dependent variables. The differences in mean range between groups were tested using an independent samples t-test. The result for the “recognising abuse” dependent variable showed that the randomly selected set of 6 responses had a wider range ( $M=6.23$ ,  $SE= 0.43$ ) than participants’ set of 6 responses ( $M= 4.75$ ,  $SE= 0.16$ ). This difference was significant  $t(203) = -3.51$ ,  $p>0.001$ . This means that cases were not independent, and the assumption was violated. The result for “reporting abuse” dependent variable also showed that the randomly selected set of responses had a wider range ( $M= 7.3$ ,  $SE= 0.54$ ) than the participant’s set of responses ( $M= 4.61$ ,  $SE=0.18$ ). This difference was significant  $t(204) = -5.67$ ,  $p>0.001$ . However authors such as Taylor (2006) state that ordinary least squares is robust enough to cope with non-independence of cases. Furthermore in a review of the factorial survey literature, Wallander (2009) found that the studies that had used a ‘double check’ method analyses, where analyses is repeated using a sample of only one vignette per respondent, found that their initial estimates were robust; she also reported that not all factorial survey researchers view intrarater correlation as necessarily problematic, and that issues usually arise when each person rates over 30 vignettes. Therefore it was decided to proceed with the regression despite this assumption being violated.



**Linearity;** this assumption was checked using P-plots and was met.

Although the selection of factors to be presented in each vignette was random, the number of times that each factor had been presented was checked to ensure that all had been covered. The results are displayed in Appendix T and show a remarkably even presentation of the factors across the vignettes.

## 9.4 Results.

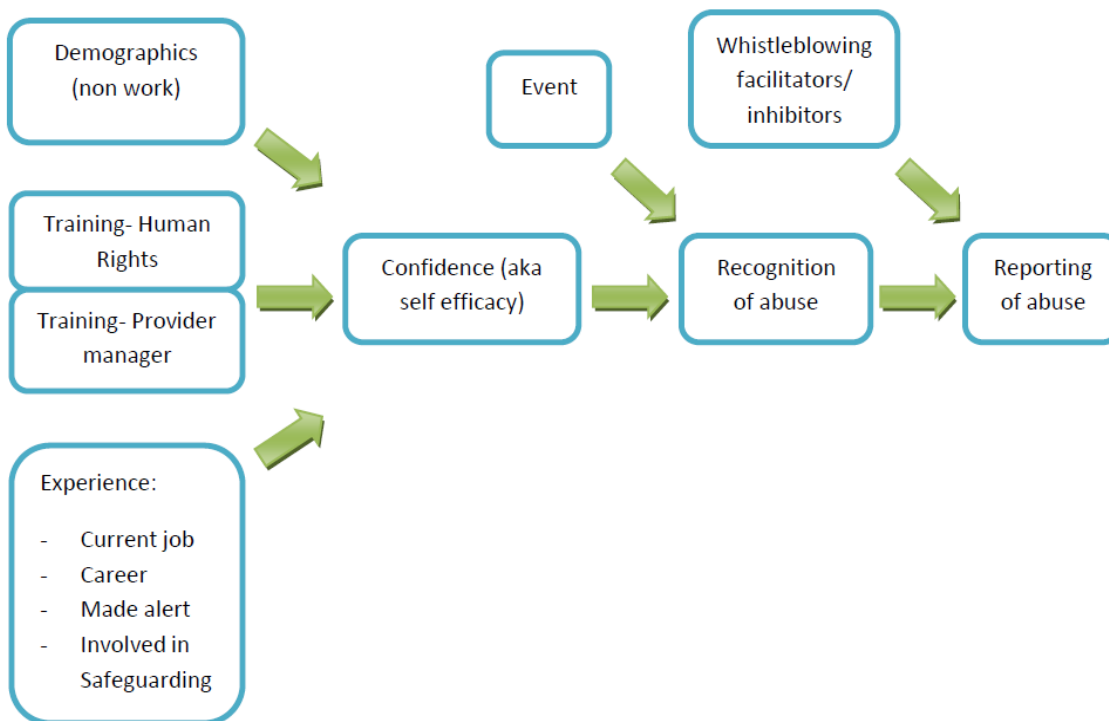


Figure 17: Model of factors to test in the factorial survey

The model above, which resulted from the realist synthesis in Chapter 7, was tested using 3 separate multiple regression models. First, the predictors of confidence were analysed; then recognition of abuse was regressed on confidence and event-related factors; then reporting of abuse was regressed on recognition of abuse and whistleblowing facilitators/ inhibitors. The research was regarded as exploratory, and so a step down approach was used.

De Vaus (2002) discusses a number of courses of action to take when dealing with outliers. All three analyses performed here revealed a small number of outliers on inspection of casewise diagnostics. Outliers are an extreme numeric value in a distribution, and can exert undue influence on some statistics; this includes the slope of the regression line, and the size of a correlation (De Vaus, 2002). They are identified using a number of methods; identification through standardised residual values was used here. This is the difference between the actual and predicted value of a case. In this analysis, the solution of dropping outlier cases was used. This course of action was decided on after eliminating the other options outlined by De Vaus; the data had been checked; the variable had already been transformed; the variable could not be deleted, because it was the variable of interest and changing the score of the outlier case was deemed too complex a task. The  $R^2$  value is reported pre and post dropping outliers, in order to indicate the impact that the outliers had on the regression line. Appendix U shows the pre outlier removal regression models. In cases where over 20 outliers were dropped, the group of outliers was examined for patterns.

The results are outlined below.

#### 9.4.1 Confidence:

A total of only 5% of the variance in confidence was explained by the factors posited in the model. The high level of multicollinearity between personal and work demographics meant that only the demographic variables “Length” (length of time working in the sector as a whole) and “Current length” (length of time working in current job) could be included in the model. However the phrasing of the question may have affected ratings; the question asked “How confident are you that this is the right thing to do” after recognition and reporting ratings had been made, making ratings

situation specific rather than general. Therefore it was considered necessary to run a wider analysis including situation-based factors as well. It is possible that the construct “confidence” is influenced by a multitude of things, including the current situation.

	<b>B</b>	<b>Std. Error</b>	<b>Beta</b>
<b>Step 1</b>			
Length <5 vs. >5 years	-1.232	.278	-.388***
Current Length <5 vs. >5 years	.335	.107	.107**
All Training	-.480	.192	-.352*
Involved Dichotomy yes/no	.913	.322	.304**
Made alert dichotomy yes/no	-.199	.362	-.064
Training x length	.372	.105	.614***
Training x made alert	.157	.120	.256
Training x involved	-.210	.127	-.361
<b>Step 2</b>			
Length <5 vs. >5 years	-1.107	.253	-.349***
Current Length <5 vs. >5 years	.302	.106	.096**
All Training	-.503	.166	-.370**
Involved Dichotomy yes/no	.513	.104	.171***
Training x length	.325	.094	.536***

**Table 12: Confidence regression results: demographic factors only**

Note:  $R^2 = .058$  for Step 1.  $R^2$  change was  $-.006$  for Step 2.

\* $p < 0.05$  \*\* $p < 0.01$  \*\*\* $p < 0.001$

What is interesting about the findings about is the effect of training. Training on its own makes a significant, negative contribution to confidence. Being involved in safeguarding makes a significant, positive contribution. Similarly the interaction variable training x length positively affected confidence. This implies that training on its own is not enough to improve the confidence (self-efficacy) of staff; in fact it

appears to decrease confidence, perhaps by sensitising staff to the complexity of making safeguarding judgements. This relates to the “conscious competence” model of learning, where learners move from unconscious incompetence, to conscious incompetence, to conscious competence (Chapman, 2010). If this model is adhered to, ratings should be interpreted in different ways depending on which stage the participant is in; high confidence ratings mean different things to people who are unconsciously incompetent and consciously competent. However it appears that opportunity to practice their skills over time, or first-hand experience of the subject in question is needed for confidence to grow.

Length of time working in health and social care (under 5 years was coded 0, over 5 years was coded 1) negatively predicts confidence; people who have worked in the sector for longer have less confidence than those who have not worked as long. Again, this may relate to the conscious competence model as above. However length of time in current job positively predicts confidence. This may be due to familiarity with policies and procedures, institutions, clients and staff in the current role. However the high degree of multicollinearity, and low  $R^2$  makes these conclusions tentative and in need of further research.

Due to the low amount of explained variance, a step-down regression including vignette factors was carried out to see whether vignette variables should be included in the model. Step 1 included the factors included in the initial model; non-significant factors were removed and vignette factors were then added, and leading to the results labelled as Step 3.

Casewise diagnostics revealed that 34 cases had a standardised residual greater than 2 or less than -2. In an ordinary sample, 5% of cases would be expected to fall outside of

these limits (Field, 2009), and the value here is 3.2%. Likewise, 1% would be expected to fall outside of +/-2.5, and 12 cases (1.1%) do so here. The sample therefore appears to conform to expectations for a fairly accurate model. One standardised residual was over -3. This was removed and the analysis run again; Table 13 shows results minus the outlier. Removing the outlier had a minimal effect on the value of R<sup>2</sup> (see notes below table).

	<b>B</b>	<b>Std. Error</b>	<b>Beta</b>
<b>Step 1</b>			
Length <5 vs. >5 years	-1.099	.252	-.347***
Current Length <5 vs. >5 years	.292	.106	.093**
All Training	-.504	.165	-.371**
Involved Dichotomy yes/no	.519	.104	.173***
Training x length	.325	.094	.538***
<b>Step 2</b>			
Length <5 vs. >5 years	-1.170	.246	-.370***
Current Length <5 vs. >5 years	.325	.103	.104**
All Training	-.544	.161	-.401***
Involved Dichotomy yes/no	.483	.101	.161***
Training x length	.347	.091	.574***
Manager & colleague support	-.006	.177	-.002
Whistleblowing support	.163	.180	.055
Person: Learning disability (vs. older person)	.116	.136	.031
Person: Mental health (vs. older person)	.012	.134	.003
Person: Physical disability (vs. older person)	.101	.134	.028
Person: Learning & Physical disability (vs. older person)	.250	.140	.064
Psychology of victim	-.008	.116	-.003
Abuse type: Physical (vs. Psychological)	.199	.123	.059
Abuse type: Financial (vs. Psychological)	.171	.126	.048
Abuse type: Neglect (vs. Psychological)	.378	.121	.112**

Severity of abuse	.340	.060	.187***
Victim perception: don't like colleague (vs. get on well)	.332	.133	.106*
Victim perception: disclosure (vs. get on well)	.400	.132	.127**
Victim attitude to sharing info	.013	.116	.004
Your perception: good friends (vs. never been friendly)	.046	.189	.014
Your perception: hasn't had much training (vs. never been friendly)	-.150	.106	-.047
Difficulty rating	-.077	.076	-.107
<b>Step 3</b>			
Length <5 vs. >5 years	-1.206	.245	-.381***
Current Length <5 vs. >5 years	.303	.102	.097**
All Training	-.555	.160	-.409***
Involved Dichotomy yes/no	.483	.100	.161***
Training x length	.359	.091	.593***
Abuse type: Neglect (vs. Psychological)	.250	.098	.074*
Severity of abuse	.369	.053	.203***
Victim perception: don't like colleague (vs. get on well)	.423	.106	.135***
Victim perception: disclosure (vs. get on well)	.490	.106	.156***

**Table 13: Confidence regression results: demographic and vignette factors**

Note: without outlier  $R^2 = .052$  for Step 1.  $R^2$  change was .083 for Step 2, and -.013 for Step 3.

With outlier, Note:  $R^2 = .052$  for Step 1.  $R^2$  change was .084 for Step 2, and -.017 for Step 3.

\* $p < 0.05$  \*\* $p < 0.01$  \*\*\* $p < 0.001$

Casewise diagnostics showed that there were still 34 outliers with a value of  $> \pm 2$ , but none with a value of  $\pm 3$ . Figure 18 shows a scatterplot of the standardised residuals (the standardised differences between the observed data and what the model predicts (Field, 2009)) against the standardised predicted values of the model. Field states that

this plot is useful to determine whether the assumptions of random errors and homoscedasticity have been met. The plot depicts a shape suggesting homoscedasticity.

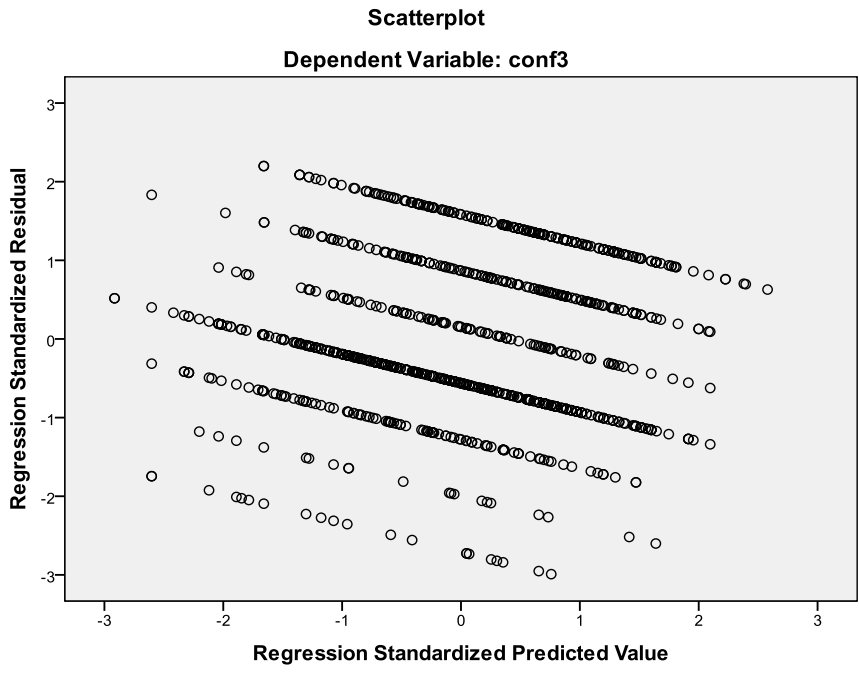


Figure 18: Scatterplot of standardised residuals against standardised predicted values: Confidence

The normality plots were also checked, and showed normal distribution.

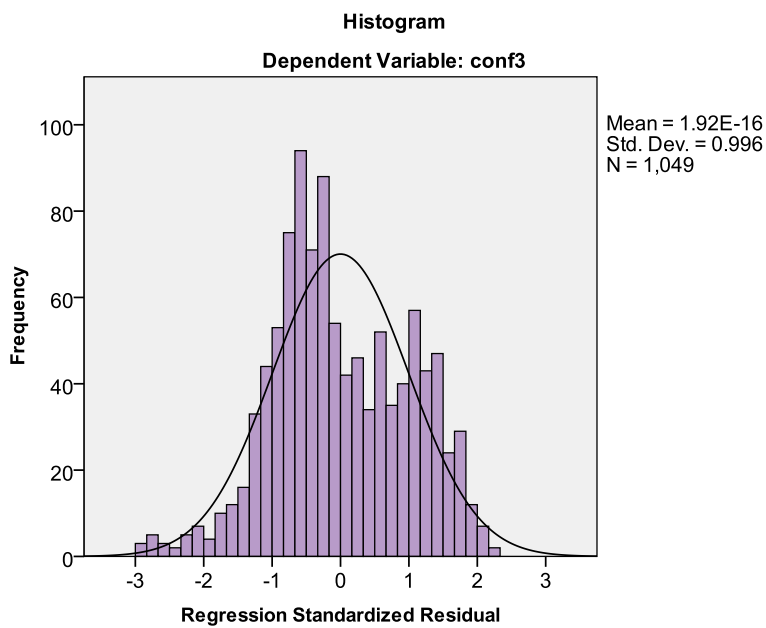


Figure 19: Normality plot: Confidence

An extra 7% of the variance was explained by adding in vignette variables, more than doubling the explained variance from just demographics, training and past experience. 12.2% of the variance was explained using this model; an extra 0.3% was explained by removing the outlier. Adding the extra vignette variables increased the value of R from .229 to .349, meaning it met the declared criteria for being a non-trivial association. The phrasing of the question may have contributed to this; participants were asked, following their ratings of recognition and reporting, how confident they were that they had made the right decision. This means confidence relating to a particular action was measured, rather than all round confidence in their safeguarding judgement abilities, and the two constructs may be different.

More severe abuse led to higher confidence that people were doing the right thing. Likewise if the victim had said they had either been hurt by the alleged perpetrator, or didn't like them, confidence was higher than if they said that they got on well. Type of abuse also featured, but only in that neglect led to higher ratings of confidence than psychological abuse. Confidence levels may be affected in a feedback loop mechanism, which considers "internal" confidence and an appraisal of the particular situation. The model should be adjusted to reflect this.

#### 9.4.2 Recognition

The predictors for recognition were listed in the model as confidence, and event based factors (situated in the vignette). A step down approach was used to input these factors. Casewise diagnostics revealed that 46 cases had a standardised residual greater than 2 or less than -2. In an ordinary sample, 5% of cases would be expected to fall outside of these limits (Field, 2009), and the value here is 4.4%. Likewise, 1% would be expected to fall outside of +/-2.5, and 10 cases (0.9%) do so here. The sample



therefore appears to conform to expectations for a fairly accurate model. 6 standardised residuals were over +/-3. These were removed and the analysis run again; 2 further outliers were removed before the final analysis, which is shown in the table below. Removing the outliers affected the R<sup>2</sup> value, which changed from .352 to .373 in the final model.

	B	Std. Error	Beta
<b>Step 1</b>			
Difficulty rating	-.338	.225	-.287
Person: Learning disability (vs. older person)	.120	.187	.020
Person: Mental health (vs. older person)	.067	.184	.011
Person: Physical disability (vs. older person)	-.063	.184	-.011
Person: Learning & Physical disability (vs. older	.218	.194	.034
Abuse type: Physical (vs. Psychological)	.820	.185	.149***
Abuse type: Financial (vs. Psychological)	.495	.174	.085**
Abuse type: Neglect (vs. Psychological)	.265	.167	.049
Victim perception: don't like colleague (vs. get on well)	.136	.277	.027
Confidence	.353	.042	.218***
Psychology of victim	-.182	.257	-.038
Victim attitude to sharing info	-.313	.256	-.065
Your perception: hasn't had much training (vs. never been friendly)	-.129	.146	-.025
Severity of abuse	1.20	.113	.408***
Perpetrator past behaviour	-.001	.255	.000
Victim perception: disclosure (vs. get on well)	.828	.272	.162**
Whistleblowing support	-.064	.171	-.013
Your perception: good friends (vs. never been friendly)	.430	.475	.083
Support	.661	.469	.195
<b>Step 2</b>			
Difficulty rating	-.176	.044	-.149***

Abuse type: Physical (vs. Psychological)	.740	.145	.134***
Abuse type: Financial (vs. Psychological)	.343	.151	.059*
Confidence	.374	.041	.231***
Severity of abuse	1.24	.076	.423***
Victim perception: disclosure (vs. get on well)	.824	.129	.162***
Support	.291	.123	.086*

Table 14: Recognition regression results

Note: Without outliers:  $R^2 = .373$  for Step 1.  $R^2$  change was  $-.009$  for Step 2.

With outliers:  $R^2 = .352$  for Step 1.  $R^2$  change was  $-0.008$  for Step 2,  $-0.002$  for Step 3 and  $-0.002$  for Step 4.

\* $p < 0.05$  \*\* $p < 0.01$  \*\*\* $p < 0.001$

A scatterplot of the standardised residuals against the standardised predicted values of the model is shown below. The plot depicts a shape suggesting homoscedasticity.

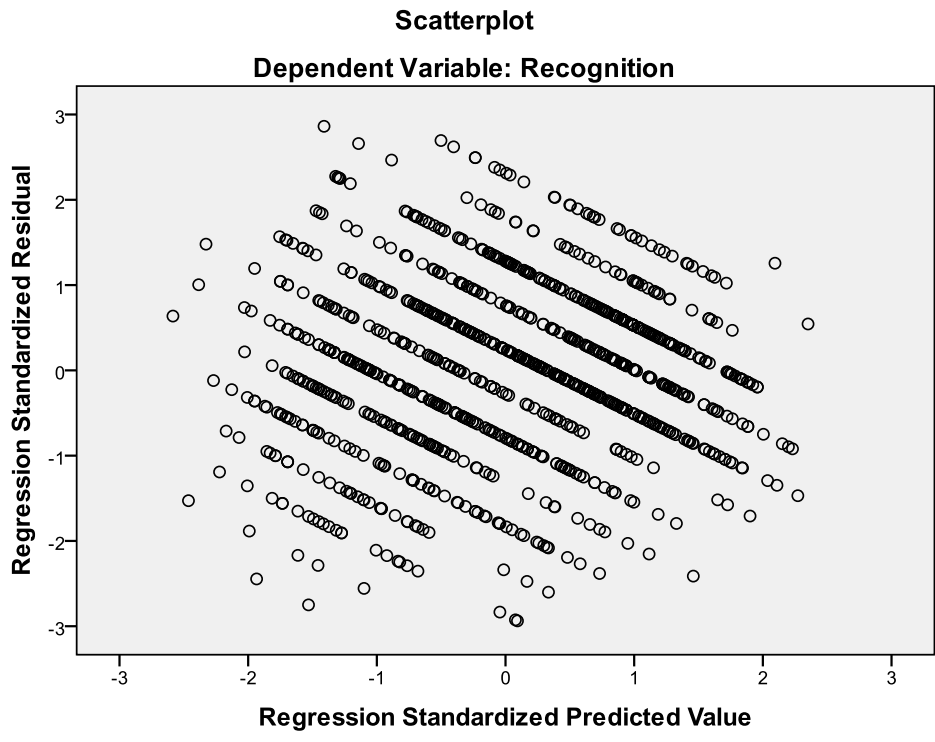


Figure 20: Scatterplot of standardised residuals against standardised predicted values: Recognition  
 The normality plots were also checked, and showed normal distribution:

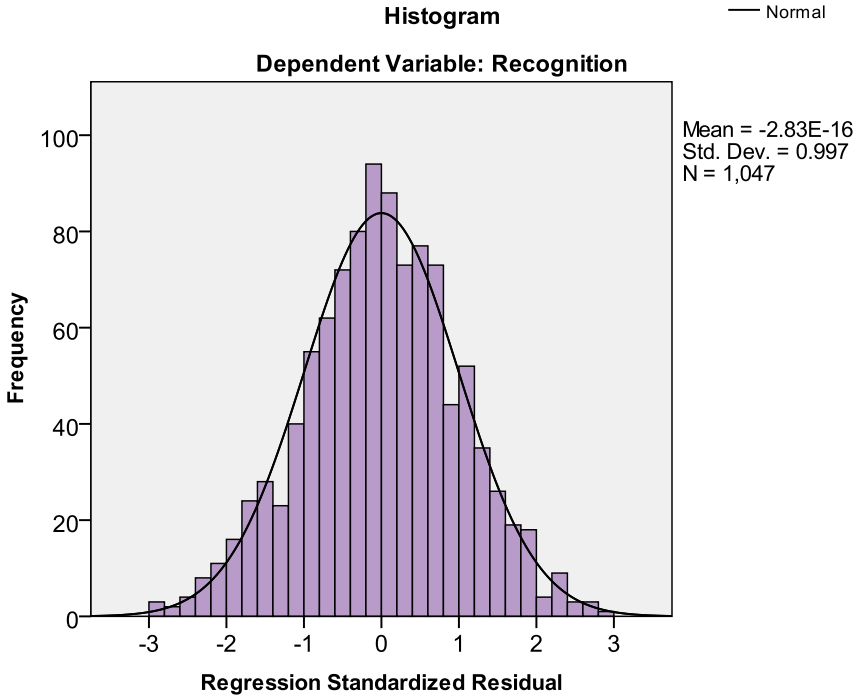


Figure 21: Normality plot: Recognition

The final model explained 36.4% of the variance of recognition of abuse. Removing the 8 outliers resulted in an extra 2.5% of the variance being explained. The R value was .603, exceeding the declared significance criteria. The relationship between confidence and recognition, which was positive and significant, needs further consideration. The results indicate that confidence is higher when recognition of abuse is higher; so people feel more confident that they are doing the right thing when they rate recognition highly. This represents a strategy corresponding to the 'if in doubt, refer' policy- that it is better to express a concern about suspected abuse, even if the suspicion later turns out to be unfounded, than ignore it with worse repercussions later on.

The "Support" variable was created from combining the vignette variables of organisational support, and manager support into one. Coding was 0 for having neither organisational nor managerial support, 1 for having one of them, and 2 for having a supportive organisation and manager. A supportive climate was a positive predictor of recognition of abuse.

There seemed to be a clear effect of type of abuse on recognition. Physical abuse was most likely to be recognised, followed by financial abuse. There was no significant difference between neglect and psychological abuse, which was coded as the reference variable in the set of dummy variables. Severity of abuse had a strong, significant and positive predictive effect on recognition of abuse- the more severe, the more likely that abuse would be recognised.

The victim's perception of the perpetrator also had a strong predictive effect on recognition of abuse. A disclosure that the alleged perpetrator had hurt them

predicted higher recognition of abuse than if the victim said that they got on well with the perpetrator.

The final predictor was scenario 'difficulty rating', which reflected how hard it would be to make an alert in that situation, considering all factors (see section 6.3.14). This scale was constructed following individual ratings of how difficult it would be to make an alert by the researcher, and an Independent Safeguarding Chair. A low rating meant it would be easy to make an alert in the situation. The results indicate that difficulty rating and recognition of abuse were inversely related; a higher difficulty rating resulted in lower recognition of abuse. The difficulty rating represents all factors in the vignette, including type and severity of abuse, characteristics of the victim, relationship with perpetrator, and organisational factors.

### 9.4.3 Reporting

The model postulates that recognition of abuse and facilitators or inhibitors of whistleblowing will be the main predictors of reporting abuse. Factors included under the facilitators/ inhibitors of whistleblowing included difficulty rating, relationship with the perpetrator, support (comprising organisational and management support), and whether the perpetrator had been observed carrying out the behaviour before.

Casewise diagnostics revealed that 55 cases had a standardised residual greater than 2 or less than -2. In an ordinary sample, 5% of cases would be expected to fall outside of these limits (Field, 2009), and the value here is 5.2%. Likewise, 1% would be expected to fall outside of +/-2.5, and here and 27 cases (2.5%) do so here. This is higher than usual, meaning results should be interpreted with caution. 13 standardised residuals (1.2%) were over +/-3. These were removed and the analysis was run again. The

removal of the 13 extreme outliers resulted in a substantial increase in amount of variance explained;  $R^2$  increased from .587 to .644. Inspection of the resulting casewise diagnostics highlighted 64 outliers, 6.1% of the sample of 1042. Of those, 21 were between +/- 2.5 and 3 (2%) and 3 were over +/-3 (0.3%). On the subsequent 6 times the analysis was run, outliers of +/-3 appeared. A total of 22 outliers were removed over 8 iterations, leaving the final model below. The extreme outliers, which make up about 2% of the sample, were examined in more detail to see if any discernible patterns were evident (see 9.4.4). The final analysis yielded 66 outliers, 6.4% of the sample. 21 (2%) were between +/-2.5 and 3.

	B	Std Error	Beta
<b>Step 1</b>			
Support	.298	.112	.083**
Recognition of abuse	.821	.020	.786***
Your perception: good friends (vs. never been friendly)	.387	.132	.071**
Difficulty rating	-.195	.045	-.155***

Table 15: Reporting regression results

Note: Without outliers  $R^2 = .667$ .

With outliers,  $R^2 = .587$

\* $p < 0.05$  \*\* $p < 0.01$  \*\*\* $p < 0.001$

A scatterplot of the standardised residuals against the standardised predicted values of the model is shown below. The plot depicts a shape suggesting homoscedasticity.

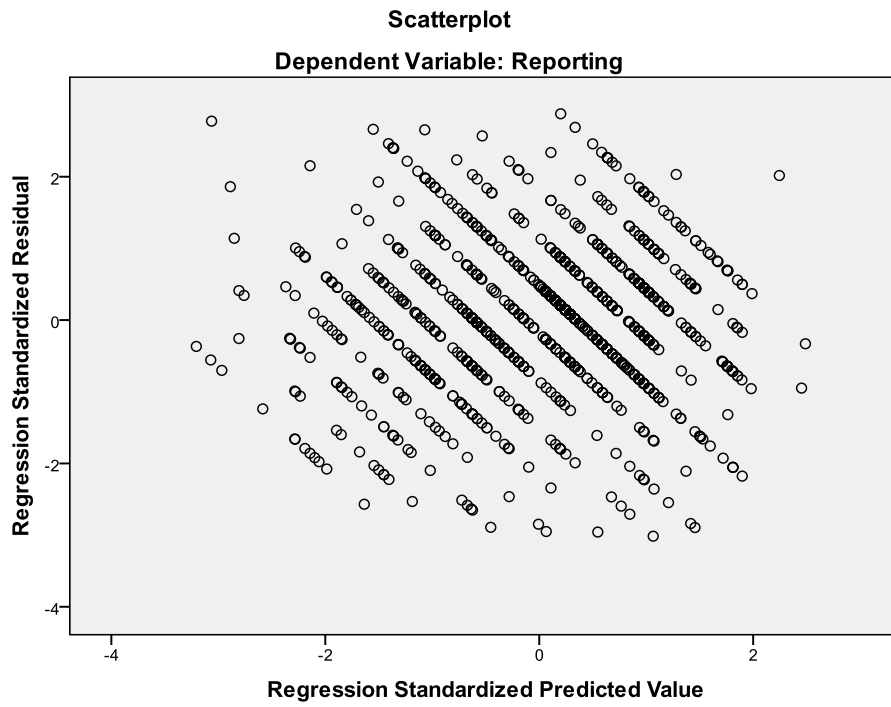


Figure 22: Scatterplot of standardised residuals against standardised predicted values: Reporting

The normality plots were also checked, and showed normal distribution:

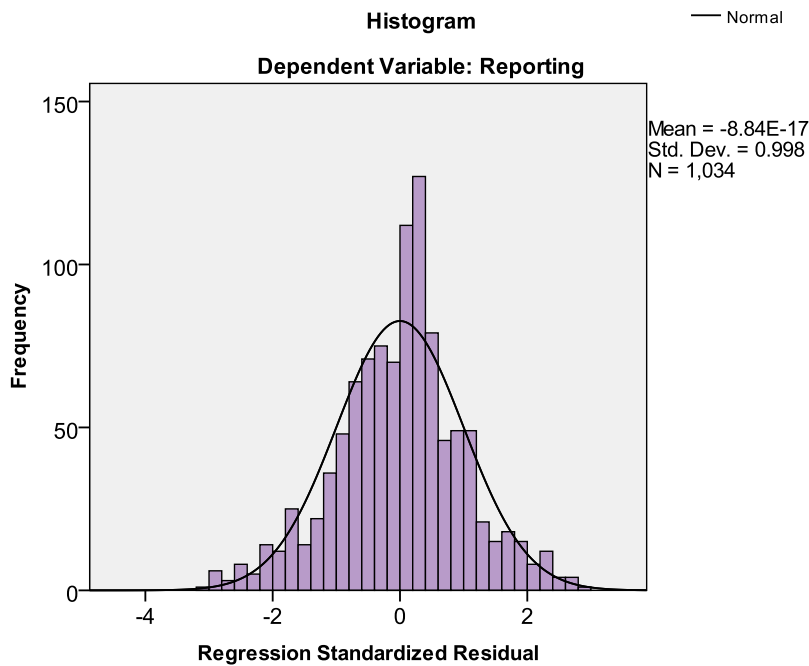


Figure 23: Normality plot: Reporting

R was .816, exceeding the declared significance criterion. The strongest predictor of reporting was recognition of abuse; high ratings of recognition of abuse predicted high ratings of reporting of it. As with recognition, difficulty rating (determined by the measure created by the Independent Chair and researcher) had an inverse relationship with reporting; the harder it was to make an alert, the less likely one would be made. Level of support positively predicted reporting of abuse. Surprisingly, people were more likely to report a good friend than someone they had never been friendly with.

#### 9.4.4 Review of outliers:

The 22 outliers were analysed to see if any patterns were evident. Analysis showed that they originated from 15 participants; one participant had all 6 of their vignette responses removed due to outlier status. Two further people had 2 vignette responses removed.

In terms of participant characteristics, 1 worked in Adult Care and Support, and 6 in the NHS. The remainder were based in the Private or Independent sector. All participants were care workers (as opposed to ancillary or admin staff), and included 5 professionals, 2 managers, 1 senior support worker, 6 support workers, and 1 training professional. People had attended a range of training, from none to the highest level, and their qualifications ranged from none to postgraduate. There were no patterns regarding past involvement in safeguarding or alerting. 12 of the 15 had worked in health and social care for less than 5 years but participants had a wide range of ages. 12 of the 15 had also worked in their current role for less than 5 years.

Vignette characteristics were also looked at to see if a particular factor or combination thereof may have led to the outliers. None of the vignette factors stood out as being



consistently presented, or not presented in the vignettes, and the difficulty rating scores were distributed across a large range of the scale.

Lastly, the outliers were split into those whose reporting values were positive, i.e. much higher than predicted by the model (n= 14), and those which were negative, i.e. much lower than predicted by the model (n=8). The people with more than 1 outlier included tended towards the same bias (all positive, or all negative). People who gave a reporting score much lower than expected were more likely to have been more involved in safeguarding (6/8) than those who over-scored reporting (2/14). Likewise 4/8 participants whose reporting score was lower than expected had made an alert before, compared to only 1/ 14 of the over-reporting group. There did not appear to be any other obvious patterns in the data.

In summary, it appears that only 'person' and previous involvement in safeguarding and alerting link the outliers. However the patterns were not consistent, so it is unlikely that excluding the outliers will systematically have biased the findings.

## **9.5 The model reviewed**

The results above show a reasonable fit with the posited model (the revised programme theory following the realist synthesis review), with the exception that the dimension of confidence needs some input from the particular situation as well as demographic factors, training and past experience. The relationship between training and confidence is more complex than expected; training alone leads to a decrease in confidence, whereas when it is included in an interaction variable with length of time working in health or social care, it positively predicts confidence. This implies that

following training, opportunity to practice skills is needed in order for confidence to increase- a concept supported by the training transfer literature (D'Netto, Bakas & Bordia, 2008; Devos *et al.*, 2007; Meyer *et al.*, 2007). Involvement in safeguarding positively predicted confidence, which again lends support to this idea. An amended version of the model is shown below. The green arrows represent relationships that were predicted in the initial model. Orange arrows show unexpected relationships, and new factors. The “Opportunity to use” factor is an amalgamation of elements of “Experience” and “Demographics”.

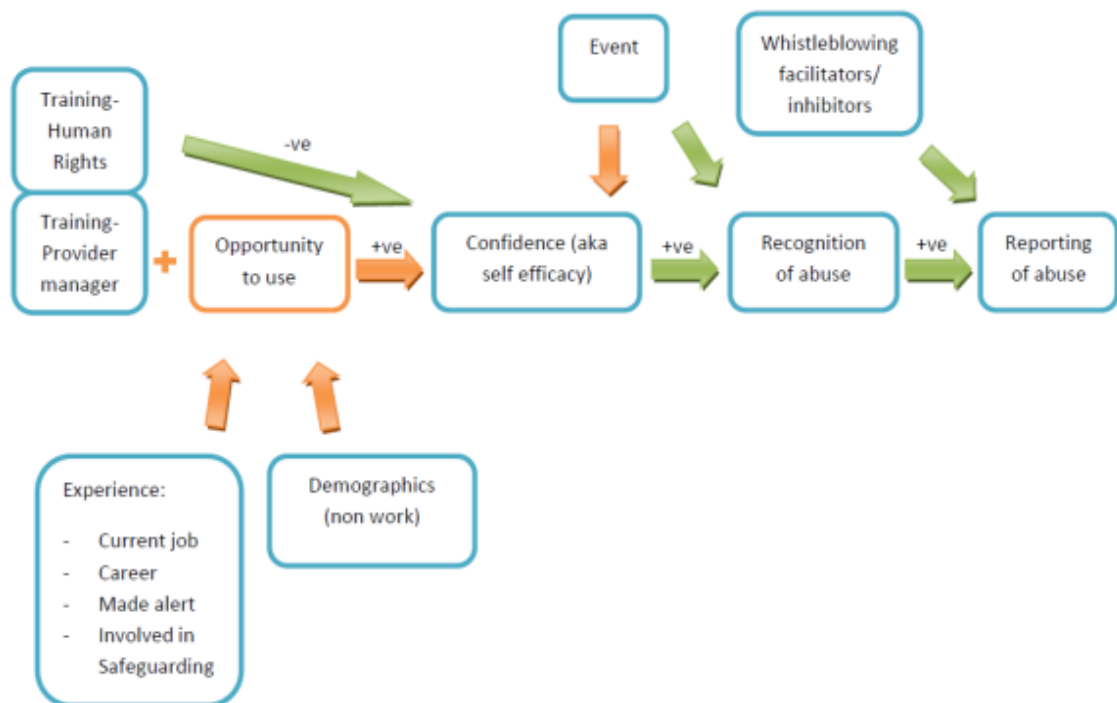


Figure 24: Revised model of impact on training and other factors on confidence, recognition and reporting of abuse.

This model represents a number of changes to the original model outlined in Figure 11. The table below shows the causal propositions proposed at the end of Chapter 7 and amendments to them following the factorial survey.

Demographic factors influence confidence in ratings	Supported: these were combined with past experience into factor termed “opportunity to use”. Different factors affect in different ways; e.g. length of time working in health and social care is negatively related to confidence, while length of time in current job is positively related to confidence.
Training level influences confidence in ratings	Supported: but in a direction opposite to that which policy would imply. Training decreases confidence unless it is combined with experience of safeguarding, or opportunity to use.
Past experience of safeguarding influences confidence ratings	Supported: more experience leads to higher confidence
Current job level influences confidence ratings	The analysis could not include job level, due to multicollinearity with other factors
Experience working in the sector influences confidence ratings	Supported: having worked in the sector for longer leads to lower confidence
Experience working in current job influences confidence ratings	Supported: having worked in the current job for longer leads to higher confidence.
Confidence influences recognition of abuse	Supported: though direction of relationship is unclear. Higher recognition of abuse is related to higher confidence ratings.
Factors in the scenario affect recognition of abuse	Supported: factors including severity of abuse, type of abuse, workplace support, and a disclosure that the alleged perpetrator had hurt the victim increased recognition of abuse.
Recognition of abuse influences reporting of abuse	Supported: recognition and reporting of abuse were very strongly related
Facilitators and inhibitors of whistleblowing affect reporting of abuse	Supported: a supportive workplace led to higher reporting. Unexpectedly, if the alleged perpetrator was a ‘good friend’, reporting was higher.

NEW PROPOSITION	Factors in the vignette influence confidence levels.
NEW PROPOSITION	Training, experience, other demographic factors, and involvement in safeguarding can be combined into a factor termed “opportunity to use” which is positively related to confidence.

Table 16: Amendments to causal propositions following factorial survey

## 9.6 Categorical data

### 9.6.1 Descriptive statistics

Results of the collection of categorical data were analysed using descriptive statistics. Frequencies of each instance of an option being selected are shown below, along with the corresponding percentage of total responses.

Option	Number of times selected	% of total vignettes
No action needed	19	2%
Wait and see if it happens again	53	5%
Document the situation in case file or notes	725*	73%*
Talk to the person	577	55%
Talk to your colleague	472	45%
Talk to a colleague not involved in the situation	147	14%
Talk to another professional, e.g. doctor or social worker	347	33%
Talk to your manager	925	88%
Call 999	29	3%

Table 17: Number and percentage of times each categorical option was selected.

\* 1055 vignettes were responded to in total. The “Document the situation” option was only available in 990 of the presented vignettes, due to the option being added after

the study had commenced, when a number of participants identified it as an action they would take. This was not identified by participants in the pilot study. Percentages are rounded up to the nearest whole.

The most frequently selected action, which participants said they would take as well as, or instead of, making an alert was talking to their manager. This is in line with policy. Documenting the situation was also rated as necessary in three quarters of the presented vignettes. Interestingly, 55% of vignettes led to people saying they would talk to the alleged victim of abuse about it, while 45% prompted hypothetically talking to the alleged perpetrator. In only 2% of cases participants said that no action was needed, perhaps reflecting demand characteristics that implied that at least ‘something’ should be done. A similarly small percentage prompted calling of the emergency services. This is expected, as the situations described generally did not require urgent medical or police intervention.

### 9.6.2 Correlations

A point biserial correlation was used to correlate recognition and reporting scores with the categorical variables. Point biserial correlations are used when one variable uses interval data, and the other uses nominal data with a discrete dichotomy (Field, 2009).

The categorical data was coded 0 if it wasn’t selected and 1 if it was.

		Recognition	Reporting
<b>No needed action</b>	Pearson Correlation	-.277	-.251
	Sig. (2-tailed)	.000***	.000***

	N	1055	1055
<b>Wait &amp; see</b>	Pearson Correlation	-.162	-.128
	Sig. (2-tailed)	.000***	.000***
	N	1055	1055
<b>Document</b>	Pearson Correlation	.168	.230
	Sig. (2-tailed)	.000***	.000***
	N	989	989
<b>Talk to person (alleged victim)</b>	Pearson Correlation	-.052	-.039
	Sig. (2-tailed)	.094	.207
	N	1055	1055
<b>Talk to colleague (alleged perpetrator)</b>	Pearson Correlation	-.153	-.177
	Sig. (2-tailed)	.000***	.000***
	N	1055	1055
<b>Talk to other colleague</b>	Pearson Correlation	-.009	-.038
	Sig. (2-tailed)	.778	.221
	N	1055	1055
<b>Talk to professional</b>	Pearson Correlation	.163	.148
	Sig. (2-tailed)	.000***	.000***
	N	1055	1055
<b>Talk to manager</b>	Pearson Correlation	.319	.281
	Sig. (2-tailed)	.000***	.000***
	N	1055	1055
<b>Call 999</b>	Pearson Correlation	.071	.096
	Sig. (2-tailed)	.021*	.002**
	N	1055	1055

Table 18: Correlation matrix showing recognition and reporting scores versus actions chosen

The table shows that particular actions are correlated with recognition and reporting of abuse score. As recognition and reporting score increases, participants were more

likely to say they would document the situation, talk to a professional, talk to their manager, or call 999. However, they were less likely to say that no action was needed, wait and see what happened or talk to the alleged perpetrator. This implies that people are more likely to try and resolve the situation themselves, by talking to the alleged perpetrator, when abuse levels are lower. There was no relationship found between recognition or reporting score and talking to the alleged victim of abuse, or talking to other colleagues not involved in the situation.

No significant correlations were found between the categorical variables and level of training. The level of safeguarding adults training reported had no relationship with the actions that participants said they would take in the response to the vignettes. Neither severity of abuse nor difficulty rating of the scenario had a relationship with the actions either. 2 categorical variables significantly correlated with confidence; choosing to “Wait and see” was negatively correlated with confidence ( $r = -.152$ ,  $p < .05$ ) and choosing to “talk to your manager” was positively correlated with confidence ( $r = .197$ ,  $p < .01$ ).

### 9.6.3 Chi squared analysis

Further analysis was carried out on the relationship between pairs of categorical variables using the chi-square test. The test assumes independence of data, meaning that each person only contributes to one cell of the contingency table. Each person completed 6 vignettes in this study, which would contribute towards 6 cells, so it was decided to run the analysis on only one set of vignettes.

The test was carried out on factors which were shown to have a significant effect on the dependent variables in the regression model. Factors which could rationally be

linked (such as the impact of personality of the alleged victim on talking to them about the alleged abuse) were tested; a table of the pairs of variables that were tested is below (see Table 19). A number of significant associations were found between experience and previous involvement in safeguarding (which are both dichotomous variables here) and actions chosen in response to the vignettes.

There was a significant association between the following pairs of factors:

- Involvement in safeguarding, and whether or not people said they would document the situation  $\chi^2(1) = 6.545, p < 0.05$ . Based on the odds ratio, this seems to represent the fact that the odds of documenting the situation were 2.5 times higher if they had been involved in safeguarding before, than if they hadn't. See Appendix V for odds ratio calculations and contingency tables.

	<b>Document</b>	<b>Talk manager</b>	<b>to Talk to the person</b>	<b>Talk to your colleague (alleged perpetrator)</b>
<b>Support</b>		$\chi^2$ non sig		
<b>Victim perception: disclosure</b>			$\chi^2$ non sig	$\chi^2$ non sig
<b>Your perception: good friends</b>				$\chi^2$ non sig
<b>Involved dichotomy</b>	$\chi^2$ sig	$\chi^2$ non sig	$\chi^2$ sig	$\chi^2$ non sig
<b>Psychology of 'victim'</b>			$\chi^2$ non sig	
<b>Current length</b>	$\chi^2$ non sig	$\chi^2$ sig 1 sided	$\chi^2$ non sig	$\chi^2$ sig 1 sided

Table 19: Pairs of factors tested using Chi Square

- Involvement in safeguarding and whether or not people said they would talk to the person  $\chi^2(1) = 5.711, p < 0.05$ . Based on the odds ratio, this seems to



represent the fact that the odds of talking to the person were 2.1 times higher when the person had past involved with safeguarding.

- Length of time working in current job (> or < 5 years) and whether or not people said they would talk to their manager  $\chi^2(1) = 3.851, p < 0.05$  (1 sided). Based on the odds ratio, this seems to represent the fact that the odds of talking to the manager were 3.35 times higher when the person had worked in their current job for over 5 years.
- Length of time working in current job (> or < 5 years) and whether or not people said they would talk to their colleague (the alleged perpetrator)  $\chi^2(1) = 3.700, p < 0.05$  (1 sided). Based on the odds ratio, this seems to represent the fact that the odds of talking to their colleague were 1.86 times higher when the person had worked in their current job for over 5 years.

All the significant chi square details are based on personal characteristics, not characteristics from the vignettes. This implies that the actions that people take are affected less by the situation than by their past experience.

## Chapter 10 Results: Interviews with Provider Manager and Human Rights delegates and Trainers

### 10.1 Introduction

Qualitative interviews with 10 attendees from the Provider Manager/ Team Leader safeguarding adults training, 10 attendees from the Human Rights workshop, and 3 trainers who deliver both programmes were analysed to answer the following research questions:

- RQ 2) What effect do the Human Rights workshop and Safeguarding Adults Managers' workshop have on delegates' practice, in terms of
- a) actions undertaken in the workplace as a consequence of attendance on the workshop
  - c) Considering the findings of a) and b), does the Manager's training add anything (in terms of actions taken or thresholds to recognising and reporting abuse) to the effect of Human Rights workshop?
- RQ 3) What factors in the workshops or workplace act as facilitators of or barriers to the transfer of learning from the workshop into practice?

Answering these research questions will contribute to the adaptation of the second iteration of the programme theory so it applies to safeguarding adults training specifically, rather than health and social care training generally. Pawson and Tilley explain,

“Programs work (have successful ‘outcomes’) only in so far as they introduce the appropriate ideas and opportunities (‘mechanisms’) to groups in the appropriate social and cultural conditions (‘contexts’).” (Pawson & Tilley, 1997, :57)

The realist synthesis highlighted mechanisms and contexts that facilitate transfer in health and social care training, but there was little evidence available concerning safeguarding adults training specifically. Issues left to address through analysis of the interview data include the impact of mandating training on motivation and transfer,

whether delegates understand that the reason for attending is ultimately to improve their performance (and services), whether adult learning principles are adhered to in safeguarding adults training (and the effect on transfer), the effectiveness of transfer supports in the context of safeguarding adults training, and whether there are any specific workplace barriers or supports to safeguarding. This analysis begins by outlining the impact (outcomes) of the training, and works backwards to determine the context and mechanism that facilitated those outcomes, specifically highlighting points not already covered in the literature review. Mechanisms can be defined as whatever generated the outcomes, and only work in particular contexts. Therefore while the outcomes are the impacts of the training, the mechanisms will be whatever aspect of the training, or the person's workplace triggered an interaction with the person to cause the change (Westhorp, 2011).

The second iteration of the programme theory of health and social care training illustrated in Figure 10 implies a number of causal propositions which are listed below. The applicability of the causal propositions to safeguarding adults training was examined by applying a retroductive approach to the interview data, which involved going back and forth between the data and the literature. Findings were then compared to the causal propositions, which are:

1. Training being mandated causes organisations to conduct learning needs analyses of their staff to determine the cause of the performance deficit.
2. Conducting a learning needs analysis results in the right people attending training
3. The identification (via the learning needs analysis) of a knowledge, skill or attitude gap, or interpersonal/ team issues leads to safeguarding adults training programmes being devised.

4. Training programmes being devised leads to trainers delivering programmes that take account of
  - a. The principles of adult learning
  - b. The principles of training transfer
5. Other Human Resources procedures address some interpersonal or team issues, or lack of ability in the job, which leads to changed practice.
6. When the right people attend training that takes account of the principles of adult learning and training transfer, skills are learned, confidence increases, attitudes are changed and/ or knowledge is gained.
7. Newly learned skills, increases in confidence, changes in attitudes and / or knowledge gains lead to changed practice.
8. Cohort attendance on training leads to shared learning and peer support, which results in changed practice when the principles of training transfer are applied in the workplace.

These causal relationships are moderated by the presence or absence of structures to support new learning, resources available to support training and transfer, and the transfer climate.

In the second iteration of the programme theory, the outcome is simply listed as “changed practice (training transfer)”, because the evidence concerned a number of programmes other than safeguarding adults. The analysis of the interview data will also lead to a clearer idea of the outcomes achieved by safeguarding adults training, as well as the mechanisms which facilitated those outcomes.

## **10.2 Impacts of the workshop**

This section describes the main impacts (outcomes) of the workshops. The antecedents of changed practice listed in the programme theory include skills being learned, knowledge being gained, attitudes being changed and confidence increasing; these propositions will be examined. Although these mechanisms can also be viewed

as outcomes in themselves, transfer in the form of changed practice is the outcome of interest in this study so classifying them as mechanisms that facilitate transfer is more appropriate. Delegates outlined a wide array of impacts that the workshops had on their practice.

<b>Provider Manager</b>	<b>Human Rights</b>
Communicating safeguarding to staff [7]	(Increased awareness, understanding or knowledge) [8]
(Increased confidence) [7]	Impact on people who use services [6]
(Increased awareness) [6]	Limited or no impact [5]
Clarifying specific issues [5]	Other practical, actioned impacts [4]
Training for others [5]	Encouraging alerting [4]
Encouraging alerting [5]	(Increased confidence) [4]
Impacts on people using services [3]	Addressing human resources or staffing issues [3]
Multiagency working [3]	
Policies and procedures [3]	

Table 20: Table of impacts of both training programmes. (Antecedents of impacts in brackets; numbers of participants who identified each impact in square brackets)

Quantitative measures such as tabulation can be a useful way for the reader to gain a “sense of the data as a whole” (Silverman, 2006, :299). Table 20 shows the number of respondents who mentioned each impact, and antecedent of impact, from each training programme. Increased awareness, understanding or knowledge was the ‘impact’ most mentioned by Human Rights attendees; this then impacted on service users. The Provider Manager training resulted in managers communicating

safeguarding to their staff, perhaps a result of their own increased confidence in their knowledge.

The impacts are explored in more depth below.

### 10.2.1 Antecedents to changed practice: confidence

Self-efficacy, or confidence is “an individual’s belief that they can successfully perform a task” (Chiaburu and Lindsay 2008:200) and is recognised as an important factor supporting transfer (Blume *et al.*, 2010; Burke & Hutchins, 2007; Devos *et al.*, 2007). This research supports the notion that confidence to use new learning is an integral aspect of safeguarding adults transfer (Pike *et al.*, 2011). An increase in participants’ confidence was a major theme to emerge in the Provider Manager interviews and was linked by some with a propensity to act:

“it actually I think gave me more confidence that if I wanted to raise an alert, that I would actually be more confident in doing so rather than thinking about it” (Delegate 1, PM)

This matches previous research concerning the impact of self-efficacy on training transfer (Devos, Dumay *et al.* 2007; Velada, Caetano *et al.* 2007).

One person explained that confidence came from knowing the legal basis of safeguarding, “rather than pure intuition, experience, and accepted wisdom” (Delegate 8, PM). Confidence also manifested itself in terms of ability to “speak with more authority on these issues” (Delegate 8, PM) and advise and mentor colleagues about safeguarding. A Human Rights attendee described a new confidence in her advice;

“I sort of knew it off pat, whereas before I wouldn’t have been able to... I’d have said oh dear oh well, pussyfooted around.” (Delegate 10, HuR)

Training and the confidence and knowledge that it gave made delegates “less fearful when the process comes up” (Delegate 5, PM) and was described as “reassuring... I don't need to worry” (Delegate 7, PM). A trainer speculated that because people in the sector often “pick up the role” (Trainer 3) of manager, their confidence can be lacking. Training that addresses management issues boosts confidence, leading to improved safeguarding.

A number of people from the Human Rights course noted that the training had given them more confidence to challenge colleagues, “raise the safeguarding card quicker” (Delegate 4, HuR), talk about safeguarding, and take decisive and less risk averse action. One person said that meeting less informed and less supported people on the training had given her more confidence in her own organisation, but also was hopeful that the training would give them the confidence to act, “regardless of what the organisation would do” (Delegate 7, HuR).

These findings imply that one mechanism by which training leads to changes in safeguarding behaviour is through increasing confidence in that behaviour and how to perform it. This develops previous literature, which has found that training increased participants’ work-related self-efficacy (Pattni, Soutar & Klobas, 2007; Taylor, Mesmer-Magnus & Burns, 2008) to relate to a context of safeguarding. Increasing confidence may be especially important here because thresholds, actions and best practice are often unclear.

### 10.2.2 Antecedents to changed practice: knowledge and awareness

Increased awareness, understanding or knowledge was mentioned by most Human Rights attendees (n=8) as a main impact of the training. The fact that increased awareness and knowledge was discussed as being a main impact in itself implies that the contextual features of the workplace were not right to facilitate the translation of new knowledge into action (transfer). However, the training effectively raised awareness of safeguarding;

“I wasn’t as aware then, that certain things were issues. And now, I would be much more aware, and I definitely think that’s because of the training.”  
(Delegate 5 HuR)

Awareness had increased around numerous issues. For one person, a specialised health professional, the Human Rights training was the first they had heard of safeguarding adults. An increased awareness and clarity around Human Rights both for staff and people who use services was mentioned, as well as “the importance of an individuals’ voice” (Delegate 5, HuR). One person “knew immediately what to do, make the phone call, fill out the form” (Delegate 10 HuR) when a safeguarding situation, her second, had occurred post training. This corroborates the premise that context is key to facilitating impacts of training; her new-found knowledge was put into practice through an opportunity to use it. However, awareness does not necessarily translate to action; one person said,

“I can’t think of a practical application... the only thing that really comes to mind is like I say just greater awareness... I’m more likely to act on that because I’m more aware of the consequences of not acting on it” (Delegate 5 HuR).



This quote again illustrates that practical application is dependent on context. Most people hadn't encountered an incident that required the safeguarding process, so may not have had an opportunity to use the training; for others, everything was "already in place" (Delegate 7, HuR) in their organisation.

Provider Manager delegates said their awareness had been raised about specific parts of the process, sources of safeguarding related support, advice and resources, or more generally about the risks of their workplace such as lone working. Specific issues were also clarified, including how to respond to self-neglect, the importance of recording, and the process of investigation. Others talked about safeguarding being "embedded" and "at the forefront of people's minds" (Delegate 6, PM).

Some Human Rights attendees talked about having a better understanding of legislation and policy including Deprivation of Liberty Safeguards, Mental Capacity Act 2005, Equalities legislation, the Human Rights Act 1998 and *No Secrets*. However one person pointed out that although she was clearer about the legalities in theory, applying it in practice was more challenging;

"I now understand that yes, we've all got the rights, but applying those rights is very dependent on the circumstances." (Delegate 9, HuR)

Another person talked about "balancing" the issues of safeguarding and mental capacity;

"it's quite a complex thing... training... made me very clear in some areas how to act, and then in others it's made me realise how grey certain areas are."  
(Delegate 4, HuR)

This implies that training acts as a gateway to realising how many things need to be taken into account when delivering care, by highlighting all the issues to consider. This resonates with the idea of training as a vehicle for moving from unconscious incompetence to conscious competence (Chapman, 2010). Consideration of all the issues related to safeguarding equates to changed practice.

Staff working in Adult Social Care have to manage numerous competing priorities, and it is possible that attending training works by increasing knowledge of a topic, which raises a priority up the list to ensure action on it. Awareness of where to get further advice, and raising awareness in their teams appeared to be important in potentiating changed practice; but it needs to be combined with an opportunity to use the new knowledge to result in changed practice.

### 10.2.3 Antecedents to changed practice: attitude change

'Changes in attitudes' was one of the prompts given to participants when asked about the impact that training had had. None of the respondents explicitly mentioned changes in attitudes resulting from the training. This may be explained by demand characteristics (as people may not have wanted to admit that their attitudes needed changing), lack of awareness of how attitudes had changed, or because the training was not explicitly about changing attitudes. Furthermore, attitudes may be best measured through standardised instruments rather than qualitative interviews (Gonzales, Morrow-Howell & Gilbert, 2010; Westmoreland et al., 2009). However, some participants mentioned impacts which implied a change in attitude. One person talked about a person who was self-neglecting, and outlined her change of attitude from 'its client choice' to recognising potential need for intervention. Other people were making efforts to hear people's views or "taking note of what tenants say"

(Delegate 3, PM). Trainers were also able to give examples of impacts on people who use services. It could be argued that awareness raising, leading to people saying they would be more likely to take action, or had a better understanding of how everyone has Human Rights which should be upheld, could be interpreted as a change in attitude also.

#### 10.2.4 Antecedents to changed practice: skills are learned

The Human Rights workshop aims to enable delegates to identify safeguarding, mental capacity and equality and diversity issues, and be able to demonstrate how appropriate policies, procedures and tools can be used effectively. The Provider Manager workshop focuses more on knowledge than skills, including transferring learning to practice (see Appendix W ). The main skills therefore lie in recognising safeguarding adults, and other related issues, and knowing how to manage them. This skill base overlaps significantly with knowledge, and the issue of recognising and reporting safeguarding as discussed in section 10.2.2.

#### 10.2.5 Antecedents to changed practice: peer support and shared learning (cohort attendance)

Transfer was helped by having someone else from the workplace attend at the same time. Although participants stressed that delegates should not be required to attend training in pairs, people valued being able to “bounce ideas off someone else” (Delegate 2, PM) when creating action plans and having support to implement them. One trainer expressed doubts about the effectiveness of training one non-manager at a time (rather than training whole teams);

“you’re going to get definite successes [in terms of] benefit to the individual on the day, it’s how lucky are they going to be to go back and implement some change at work” (Trainer 1)

The trainer was in favour of whole team training, where appropriate, as a way to facilitate culture change.

Groups were asked about the relative advantages of single agency (whole team) training compared to multiagency training, and responses included “singing from the same hymn sheet” (Delegate 1 and 8, PM), or having a collective knowledge, becoming aware of the strengths and weaknesses in the team, heightening awareness of issues through shared experience, and addressing issues specific to your team. The main disadvantages mentioned were the challenge of releasing all staff at once, and not having any outside input. Questions were also raised about how open people would be about their practice, and the complications of workplace politics in a training setting.

There is some evidence that shared learning and peer support are mechanisms by which cohort attendance works; however the evidence was gained from people attending in pairs, not whole teams. Furthermore, as outlined in section 10.7.5 there are numerous perceived advantages to multiagency training, although there is little evidence to support its efficacy (Barr *et al.*, 1999; Hammick *et al.*, 2007).

The following sections outline the impacts that resulted from the antecedent mechanisms discussed above.

#### 10.2.6 Communicating safeguarding to others

This impact was mentioned by 7 Provider Manager and 2 Human Rights attendees, and took a number of different forms. One manager’s increase in knowledge around safeguarding had led to staff contacting her more frequently for safeguarding advice. All three trainers said impacts from the Provider Manager training had a wider reach,

with some impacts affecting organisations nationally, and thousands of staff and service users in a “ripple effect” (Trainer 3).

Some managers used supervision to communicate with their staff about safeguarding; another asked people to refresh their knowledge using e-learning programmes, “just to sort of remind everybody that... it is a serious subject” (Delegate 2, PM). Managers noted that because their awareness had been raised through training, they put safeguarding related issues on team meeting agendas more often, because “if the staff are more aware then the tenants will be more protected” (Delegate 3, PM). Another person had started to include a section on safeguarding in their newsletter.

#### 10.2.7 Encouraging alerting

Another impact for both groups was encouragement of alerting, or following up alerts that had been made previously but not responded to, “because you know how to do it, and also because you know it’s the only way” (Delegate 10, HuR). There was a raised awareness of the importance of alerting even about seemingly trivial issues because “all the pieces put together could create an alert” (Delegate 8, HuR), but also “to tick that box in case that grows arms and legs” (Delegate 4, HuR); people were aware of guarding against future negative repercussions by making an alert early. Others said the training hadn’t made any difference, because they would have made an alert anyway.

#### 10.2.8 Limited or no impact

Five people from the Human Rights workshop thought the training had either little (e.g. just raised awareness) or no impact. However there was also recognition that this may be due to factors other than training, for example lack of opportunity to use the

learning, or having not encountered any potential safeguarding situations. Further possible reasons for the lack of impact are discussed in section 10.8.2.

### 10.2.9 Policies and procedures

Most Provider Manager attendees and one manager from the Human Rights course had checked their policies and procedures after attending, and some had amended them as a result. Trainers also mentioned policies and procedures as a common impact. Three people mentioned policy impacts that had wide reaching implications and potential for effects. One person had clarified their safeguarding procedure;

“there wasn't really a procedure in place, it was just do it and we would ring round loads of people and panic until we got hold of someone that we thought was relevant really, but now me and [colleague] know what to do directly”  
(Delegate 6, PM)

Another delegate said that the training may well affect policies in the future as they were reviewed.

For some Provider Manager delegates where policies and procedures were in place, attending training had a positive impact on improving or clarifying how they should be implemented.

### 10.2.10 Impacts on people using services

The aim of safeguarding adults training is ultimately to prevent abuse from happening in the first place, or prevent it from continuing (if possible within the legal framework) if it is already occurring. The training may also prevent the occurrence of abuse, but that is difficult to know for sure, “Because if it works, you've kind of prevented it”

(Delegate 2, PM). More Human Rights (6) than Provider Manager (3) attendees cited impacts on service users.

One person noted that they had been challenging “institutional prejudice”, such as a lack of privacy for people with dementia in care homes. However although the training may have “honed some of those skills” and “made me look at safeguarding in its’ pure form” she had “strong views already” (Delegate 4 HuR). It is possible that training raises awareness of safeguarding to make it a priority among numerous other competing issues; one person noted, “it’s up to me to really make sure that he’s not being abused.” (Delegate 9, PM). Heightened awareness also led to debate over the best course of action for service users when legislation was seen to conflict- this is discussed further in section 10.9.7.

Other people found it harder to say how their clients had been affected by their training, or thought it may have long term impact, although they speculated that a better understanding of abuse “possibly or definitely protects the person” (Delegate 2, PM).

In summary, it appears that the Human Rights training is having a positive effect in terms of raising awareness of the rights of people who use services and issues to consider when providing care, and in some cases this is translated into action. However integrating the numerous strands- safeguarding, mental capacity, DOLs, and Human Rights law is not without its problems. Provider Manager training may impact on service users in a less direct way, by improving the safeguarding structures around them.

## **10.3 Provider Manager only impacts:**

### **10.3.1 Training**

Providing further training to staff was mentioned by 5 participants. Training was delivered throughout the hierarchy of organisations, from company owners to care staff, to meet different learning needs. One person explained how training front line staff had been readily supported by her organisation's director because it met his aims too. This relates to the importance of a strategic link between training and organisational objectives (D'Netto, Bakas & Bordia, 2008) and having management support (Morgan *et al.*, 2007).

One person talked about materials that she had created to inform people who use services about their rights and safeguarding, although she emphasised numerous influences of this piece of work.

The workshop appeared to lead to managers' realisation of the importance of training their staff, and raising awareness of people who used their services in some cases. It is possible that the workshop acted as a catalyst for action.

### **10.3.2 Multiagency working**

3 participants mentioned that the workshop had impacted on multiagency working. Again, these actions may not be solely attributable to the training.

## **10.4 Human Rights workshop only impacts**

### **10.4.1 Human Resource or staffing issues**

The Human Rights training stresses that everyone, including staff, have human rights and 3 people mentioned positive effects on HR practices. This included modifications to how poor practice was challenged or confronted, changes to supervision practices



(after also attending a supervision course) and an assertion to take more action on workplace gossip.

### **10.5 Comparing the impacts of the Provider Manager and Human Rights workshops**

Provider Manager attendees listed more wide ranging and specific impacts than Human Rights attendees. Human Rights impacts tended to be more around awareness, although more impacts affecting people who use services were listed. This may have been due to the content being more service user rather than service focussed, or because people in non-managerial positions are more likely to work directly with service users. The manager's course appeared to lead to a greater increase in confidence, while Human Rights sometimes led to more awareness but also questions about how best to implement legislation and policy in complex situations. Again, this may be due to the outcomes of managers' training being more task and structure based than Human Rights delegates. This was supported by one trainer, who explained that on Human Rights the aim is to

“get your radar working, we're trying to get you to think, is there any Human Rights issues here... whereas in Provider Manager, you're working with them, for them to recognise what they need to take home that will work in their organisation” (Trainer 1)

In this way, the programmes can be seen as a success. However numerous people had difficulty identifying any practical impacts. Consideration of barriers and facilitators of transfer outlined in the following sections may elucidate the mechanism by which impacts were, or were not, achieved.

The following section outlines the various stages of the implementation chain of

safeguarding adults training, and reviews mechanisms at each stage according to the data.

## **10.6 National policy, and the identification of a skill, knowledge or attitude gap necessitates training**

The analysis aimed to find out if the mandatory nature of training impacted on the premise that training should aim to meet a learning need, to address a deficit in performance (see Figure 10). To do this, participants were asked their reason for attending the training.

### **10.6.1 Impact of 'mandatory' training on reason for attending**

The realist synthesis analysis left a number of unanswered questions relating to safeguarding adults training, namely what delegates perceive the reason for attending to be, and the impact of mandating training on motivation and transfer.

All Provider Manager delegates mentioned some aspect of update, increasing knowledge, or improving understanding (including disseminating to staff) as a reason for attending the workshop. Some informal learning needs analysis was implied, although no formal analysis was mentioned. Safeguarding was described as a “big government driven issue” (Delegate 9, PM) and a “key component” (Delegate 8) of work, implying that it is a priority in the sector. 2 people mentioned personal motivation or interest as a reason for attending.

The perception of safeguarding adults training attendance to be a requirement of their role was another consideration for numerous reasons; “because it was legality” or “the Care Quality Commission... highly recommend that I attended it” (Delegate 1, PM); for “my PRTL hours for GSCC” (Delegate 10, PM); because “to be perfectly honest, I was

actually under par in terms of my training record” (Delegate 8, PM) or just because it’s “mandatory” (Delegate 9, PM).

The majority (6) of Human Rights attendees said they attended because of policy, because it was compulsory or because they were told to. People said (with humour) that they “didn’t have any choice!” it’s a “condition of working for the Trust” and “you’ve got to attend all the compulsory training” (Delegate 1, HuR). Others talked of it being something “we had to do” but also “an interesting thing to go on” (Delegate 2, HuR) or, more directly, “I was told to go!” (Delegate 3, HuR). Another delegate speculated that other people on her course were attending “because they were told to be there” and had the attitude of “another box ticked” (Delegate 7, HuR). There was a feeling of never ending training- “we have to do it for work... you get sent on zillions of training courses so that’s just one of them” (Delegate 8). Attendance was described as “a follow on” (Delegate 7) or a “part of induction” (Delegate 4, HuR). Attending appeared to be almost automatic, and somewhat passive; being “sent” (Trainer 3 and Delegate 8). Although the requirement may be well intentioned, it may detract from the purpose of training as addressing a learning need. Nolan, Davies et al (2008) note that when resources are limited, the focus of training tends to be on practical issues and legislative requirements rather than more abstract quality goals- but motivation to attend will be higher if it is framed as integral to the job, rather than because it is a ‘requirement’ (Tai, 2006).

A trainers’ view that people attend mandatory training “reluctantly” (Trainer 2) but see the benefit of it when they get there was corroborated by delegates who, when questioned further, could see the relevance in attending. However, one trainer voiced a concern that if training was not mandated, people “won’t bother” (Trainer 3) to find

out about safeguarding because there isn't a culture of taking responsibility for learning.

The finding that more junior staff in this study appeared more cynical about attending resonates with Mythen and Gidman's (2011) discussion of the tension between mandatory training and adult learning, because presumably they have less choice or control over what and when they attend than managers.

Trainers described a similar mix of attending to meet a learning need, because an "issue of whatever description" (Trainer 1) necessitated attending, or to comply. However although learning needs were recognised by some, performance deficits were not mentioned. This implies either that the crucial purpose of training- to improve performance- is not recognised in the context of safeguarding adults training, or that it is assumed that a learning and performance deficit equate to the same thing.

A number of Human Rights workshop attendees mentioned that the training had either had no, or very little impact and it is possible that this could be linked to their perceived reason for attending. One person said he didn't think the training was effective because "I didn't learn anything... they basically told me procedures that I already knew were in place" (Delegate 3, HuR). This implies that either he did not have a learning need, or no time was spent pre-course discussing how this training could improve his performance at work. Some Provider Manager attendees also described minimal impact, because their practice had been good before attending; "It's what we do anyway." (Delegate 3, PM). This raises the question of whether the right people- people with the relevant learning and performance needs- are attending training. There was some indication that attendees are a 'coalition of the willing', while people

who need training do not attend; one participant who worked with a range of care providers observed,

“we have hundreds of providers without thinking about general public who are slipping under the net, who are probably the very people who haven't attended the training who need to, are where the worst situations occur, and we find that quite common” (Delegate 4, PM)

This raises the question of what ‘mandatory’ training actually means. If it results in people who are more committed to safeguarding attending when they don’t really need to, while others ‘slip under the net’, then the implementation of mandatory training appears flawed. It appears that currently, the mandatory nature of the training may be resulting in a perception of attending to meet a requirement rather than a learning or performance need, reducing motivation to attend for more junior staff. While it encourages attendance, those who attend may not be those who most need to.

## **10.7 Training programmes are devised, and trainers deliver programmes**

The next stage of the implementation chain is that training programmes are devised, and in the following stage programmes are delivered by trainers. The realist synthesis showed that adhering to the principles of transfer and adult learning are important for learning and transfer in health and social care training generally; this section explores whether these principles are also important to safeguarding adults training transfer.

### **10.7.1 Preparation**

Delegates from both courses were asked to complete preparation work (see Appendix Q and P), and this addressed some of the principles of adult learning (Knowles, 1990).

Delegates noted that preparation made training less of a “conveyor belt” (Delegate 3, HuR) or made them think “this is actually serious” (Delegate 1, PM). Another person, irritated by it at first, concluded she was pleased to

“actually take responsibility for what I was gonna learn, not just sit there like a cow and have it fed to me but to also think about it before I went” (Delegate 4, HuR).

This implies that preparation can challenge the idea of training as a passive activity to merely ‘attend’, increasing self-direction. It also served to prompt consideration of current understanding around safeguarding and reflection on how attendance could benefit practice. Another said it was, “absolutely essential” because “going in totally unprepared you wouldn't get the best out of it” (Delegate 4, PM).

Human Rights delegates said it gave them a clearer idea of what they were meant to achieve from attending. From a trainer’s perspective, people who had completed preparation and the prerequisites appeared to engage and contribute more and have a better knowledge and awareness of issues. When people did not complete it, it was “quite a long slog to get them all to the position that you rather hope they would be when they arrived” (Trainer 1). It appears that completing preparation enhances learner readiness, which has been related to transfer (Antle, Barbee & van Zyl, 2008; Devos *et al.*, 2007; Leimbach, 2010). However other people raised the issues of time and pressures of work as reasons why completing preparation was not practical; this is arguably related to the training culture.

However, numerous people did not see the point of completing preparation- this implies that although the training provider endeavoured to adhere to adult learning principles, the workplace context was not always supportive of this. All three trainers

said that “very few” people completed preparation; 2 trainers agreed that managers were more likely to, because they were “setting an example” (Trainer 3). These findings should be interpreted with caution as it implies either a sample that is either unrepresentative, or responding to demand characteristics.

### 10.7.2 Relevance

Training relevance is an important feature of adult learning, and training transfer principles (Alliger et al., 1997). Relevance was mentioned by three people as the main factor contributing to effectiveness of safeguarding training (Antle, Barbee & van Zyl, 2008; Kennedy-Merrick *et al.*, 2008; Stolee *et al.*, 2005), while one supervisor highlighted the importance of ensuring that staff understand why they are attending;

“Relevance definitely generates interest... When they can’t readily see what the relevance is... that would take some persuasion... if you explained it they would come round.” (Delegate 5, HuR)

Trainers talked about the importance of contextualising learning to delegates’ practice, and the power of sharing experiences. One trainer, discussing the impact of training without action plans recognised that people generally won’t change their practice unless the learning is relevant;

“with those groups of people if they’ve just had a nasty safeguarding... it will hit them perfectly” (Trainer 1)

Relevance also appeared to be linked to outcomes; one person who could not list any outcomes did not see the relevance to his work.

Case studies were seen by all groups as aiding transfer, due to being easy to relate to practice. They were used as the platform for debate, discussion and sharing

experiences, which helped delegates relate the learning to situations in their workplace. Managers appreciated hearing about how other people had managed situations as it enabled them to realise that “they’re not alone” (Trainer 3) which is important in improving standards of care (Lawrence and Banerjee, 2010). This implies adhering to adult learning principles (Knowles, 1990) was important here.

The balance between providing theory and explaining its practical application is difficult to strike for all participants, but it appears that generally both programmes were viewed as relevant to practice, and this relevance was an important mechanism in the training process.

### 10.7.3 Transfer supports

The main transfer support for both programmes was an action plan (Antle *et al.*, 2009), with additional half day follow up for Provider Manager attendees. The realist synthesis highlighted the importance of post-course support or follow up in social care training, and those findings were matched here. While trainers talked about action plans being a “powerful” tool (Trainer 2 and 3) with “massive potential if people choose to use it” (Trainer 3), Human Rights workshop participants’ opinion about action plans was split; although some favoured them, others thought they were impractical;

“it all looks very nice on paper.... But if you look at all the paperwork we have to do it’s incredible...if you spend all the time documenting and evidencing what you do, you wouldn’t have any time to do it in the first place” (Delegate 3, HuR)

Learning logs were viewed less positively than action plans, with most people saying they had not looked back over them.



This may be due to lack of follow up. Five people said they did not complete action plans; although some had made points to follow up in the training many hadn't "got round to that yet" (Delegate 1, HuR). Other people could not recall what their actions were, hadn't made any action points, or had not looked at the handbook since. People who hadn't completed any actions talked about the lack of accreditation or follow up, or pressure of work as reasons; one person pointed out,

"if you haven't learnt it, writing it down isn't going to do a lot unless you're made to go back and look at what you've written" (Delegate 8, HuR)

In contrast, Provider Manager action plans were followed up in the second half day and this was positively received. One participant said that although there was a lot of emphasis on action plans in training, coming back to the second half day made her very conscious of actually doing it. The "expectation... that they will be asked to feedback" (Trainer 1) combined with follow up appeared to work as a mechanism prompting action;

"Had they not asked us to write that plan, had we not come back on the second day with the plan, it would have been less likely that I would have then implemented all the changes... So that was the key part of making the difference in the workplace." (Delegate 2, PM)

Spaced training has had some support in the literature (Kauffeld & Lehmann-Willenbrock, 2010), and here it acted as a prompt to action. Discussing action plans and achievements was considered useful both to hear about and use other people's ideas, and because it gave an opportunity to celebrate achievements.

This implies that the action plan worked as a successful mechanism in the context of follow up on the half day, corroborating previous literature. Action plans and

preparation were not consistently used, suggesting that the transfer climate may not support them. However, one delegate said that her prompt to action had not been the action plan or the 2nd half day, but having a safeguarding situation arise- this reminded her of her intentions to promote the issue of safeguarding in her team. It appears that such a trigger to action is necessary for transfer to occur, whether it is a workplace trigger, like a safeguarding situation, or an event to follow up on action plans.

#### 10.7.4 The impact of trainer characteristics and delivery

The characteristics of trainers, including perceived competence and knowledge are important in health and social care transfer (Collins, Hill & Miranda, 2008; Gauntlett, 2005), and seem to be in safeguarding adults training too. One participant commented that the trainer's confidence in the process gave her confidence about how to manage safeguarding situations, and another noted the importance of "hard hitting" presentation, because "if material's presented in a fairly half-hearted manner then that's how you take it in" (Delegate 4, PM). The widely praised enthusiasm, knowledge and confidence of the trainer appears important to transfer.

Trainers discussed their approach to facilitation as being "about enthusing rather than the stick approach" (Trainer 3) and creating a "safe environment" (Trainer 2) that facilitates openness and honesty. Trainers from the multiagency pool all have recent or current experience of front line practice and sharing their own experiences of safeguarding may have enhanced their credibility. Trainers emphasised managers' power and responsibility to create a positive safeguarding climate, and in the Human Rights course, emphasised the Human Rights of delegates as well as the people they support, "because if people are aware and appreciate their own, then they're more

likely to think about other people” (Trainer 3). They were aware of how they had to make it “meaningful and contextualised for the individual” (Trainer 1) and recognised the challenges of applying some of the concepts in practice.

#### 10.7.5 Multiagency training advantages:

While cohort approaches might support transfer, a multiagency approach to training is encouraged in policy (Department of Health and the Home Office, 2000). Participants were asked about the advantages and disadvantages that they felt a multiagency session has. Most participants identified at least 1 advantage; understanding how others work was commonly mentioned. Multiagency training was seen to reinforce the importance of communication, and helped delegates understand issues faced in other teams and areas, as well as each agency’s role and responsibilities in safeguarding and how to work together; this corroborates previous research (Pinkney et al., 2008). Other people thought organisations working on their own could be “blinkered” (Delegate 3, PM) and multiagency training prevented insularity by giving a “wider view of what’s happening in the actual county” (Delegate 3, PM) and seeing “how the whole thing works” (Delegate 1, HuR). Breaking down barriers between professions, communicating a shared responsibility and understanding of safeguarding, and swapping ideas about how to manage particular situations were also viewed as advantageous.

8 Provider Manager attendees also thought that multiagency training reinforced multiagency working, corroborating Petch (2008). One person made the point that the length and structure of the course, rather than the delegate mix, was responsible for this; “you need that longer session to get them to gel and to mix” (Delegate 1, PM).

Networking was the final theme identified in multiagency advantages. Numerous delegates made the point that the outcomes of networking depended very much on the individuals;

“the opportunities are there aren’t they and if they’re not taken, that’s not really the fault of the training” (Delegate 10, PM)

When asked if they had maintained contact with people they had met on training, most people who mentioned networking said they hadn’t, but that it was still useful to know faces.

#### 10.7.6 Multiagency training disadvantages:

Few Provider Manager attendees could think of disadvantages to multiagency training. The most common issue was that multiagency training was not specific enough to individual agencies’ needs. It was also felt that an imbalance of sectors could lead to too much focus on the dominant group. However some Human Rights attendees expressed a preference for training targeting just their profession, to make it more relevant.

There is a wide skill and seniority mix on the Human Rights workshop, which people identified as a disadvantage. One person expressed frustration at the pace of some training (not Human Rights) being geared towards “the lowest common denominator” (Delegate 3, HuR), meaning people who are more experienced can potentially get bored or withdraw. Another person observed that within the mixed group, some people

“were on a different academic and professional level to myself and it was almost like we were talking a different language.” (Delegate 4, HuR)

Relevance appears to be jeopardised, for some, by multiagency training; this point was echoed by trainers.

### 10.7.7 Multiagency conclusions

In conclusion, there were a range of opinions about whether safeguarding adults training should remain multiagency. The consensus was that manager level should stay multiagency, while opinions on lower levels were more mixed. Some people suggested a compromise would be best, with larger groups from fewer agencies attending at once. Others thought that a mixture of single and multiagency courses would meet everyone's needs. This appears to be an issue which, at more introductory levels such as Human Rights training at least, deserves further attention; what is multiagency training meant to, and able to achieve?

## 10.8 Delegates transfer learning to practice

The final stage of the implementation chain is the transfer of learning to practice, which receives little coverage in policy, but much discussion in the literature as illustrated in Chapter 7 and 8. The individual factors which have not already been discussed and workplace factors that either facilitated or hindered safeguarding transfer are discussed below.

### 10.8.1 Autonomy

Participants from the Provider Manager course mentioned the benefits of having both the autonomy and responsibility to act. Autonomy to carry out action plans without having to seek permission was highlighted as helpful because the person could "just get on and get it moving" (Delegate 2, PM) without having to have everything "signed off" (Delegate 2, PM). Although autonomy has not been mentioned in the literature, it

is related to both opportunity to use new learning, and motivation, which are both recognised as important factors in transfer (Burke & Hutchins, 2007). Trainers talked about managers as “extremely powerful, potentially, implementers of change” highlighting the fact that it was “within their gift to implement a... change of process” (Trainer 1). This was emphasised by trainers on the course and may have contributed to the confidence boost that many managers felt.

### 10.8.2 Training culture

The culture around training is a contextual feature that influences the transfer climate, defined as “those situations and consequences in organisations that either inhibit or facilitate the use of what has been learned in training back on the job” (Burke & Hutchins, 2007, :282). Perceptions of this culture and climate featured strongly in the interviews, and influenced transfer. Culture “denotes the prevailing assumptions and beliefs within a group, that which is ‘taken for granted’” (Harrison et al., 1992) and a distinction was made between the perceived training culture of the health and social care sector generally, and the training culture of individual organisations. Organisational culture is a concept with no universally agreed on definition, nor accepted, psychometrically validated measures (Scott *et al.*, 2003) but one interpretation is “the collection of relatively uniform and enduring values, beliefs, customs, traditions and practices that are shared by an organisations’ members” (Huczynski & Buchanan, 2007, :843). Bates and Khasawneh explain how culture influences climate, as climate is “based on what an individual senses in and about the organizational environment” (2005, :99). Logically then, a sector wide or organisational training culture will impact on whether the mechanisms provided in the training course result in outcomes; this premise was supported here.

The overwhelming perception of the sector's training culture was negative.

A recurring theme among all groups, as discussed in section 10.6.1 was of training as a tick box or "bead counting" exercise, where the primary concern is "compliance" (Trainer 1); one person observed, "they just wanted to... look like they were training us" (Delegate 8, HuR). Another described the training culture in social care as "collecting certificates" and questioned that if no one is following up, "who is it for, what's it achieving?" (Delegate 10, HuR). There was little mention of the culture being a learning one;

"organisations do it [training] either for a legal requirement, for insurance or because it looks good... And whether it does any good or not actually falls by the wayside" (Delegate 3, HuR)

This raises important questions about how training is framed in the sector. Organisations cannot be blamed for creating such a culture, when having 'untrained staff' is frequently cited as a factor contributing to safeguarding issues (Aylett, 2008; Care Quality Commission, 2011a); a warning against training being perceived as a panacea has been highlighted in the context of safeguarding children (Buckley, 2000). Trainers talked about one organisation incurring financial penalties if sufficient staff do not attend (regardless of learning need or outcome), and one described "a sigh of relief, there's another one who's done it" (Trainer 3). The literature would imply that the issue is more subtle as even if staff have 'been trained', it is whether they have transferred that matters.

However some people, while recognising the sector wide culture, were making efforts to create a different culture in their own organisation. One person (who had listed extensive impacts) expressed an understanding of the purpose of training as a change

mechanism:

“it’s in my best interest for people to actually learn and make a difference, it’s not in my interest to send them on a course to tick a box to tell CQC that we’ve done all the training, I need them to make a difference” (Delegate 2, PM)

There is some evidence that proximal factors (culture of the organisation or peer support) are more important than distal factors (culture of training in the sector) in terms of affecting transfer (Martin, 2010) - this may explain how some participants managed to transfer despite a negative perception of training culture in the sector. Managers from both courses were asked about how they supported training transfer in their staff, and despite cynicism about the culture generally, returned some positive answers including discussion in supervision and appraisal, post training questionnaires, following up practice issues, being approachable, and role modelling best practice.

Financial and resource pressures also impacted on training culture. Times of economic hardship where social care funding is scarce highlight the inefficiency of a system that demands training irrespective of learning need.

Other people highlighted individual responsibility for transfer. One manager pointed out “it’s their [the staff’s] training it’s not my training, and we all have to be responsible for our own learning as well” (Delegate 5, PM). A social worker discussed his efforts to create a “sacrosanct boundary” around training where general work issues could not interrupt. He concluded that although valuing training has to come from an organisation, “you actually have to take it on board yourself as an individual” and then “make time” to attend and transfer (Delegate 8, PM).



This highlights the importance of organisational cues around training, in terms of the degree to which it is valued. Valuing training is pivotal in transfer; it could be argued that the lack of transfer, evaluation, follow up, preparation, forming of action plans or acting on them all comes down to not valuing training enough, because if training isn't valued then why would staff be motivated to do any of those things? This was supported by a trainer who talked about a contributing factor to consistent 'no shows' by NHS staff as their "cultural issue around training in those organisations" (Trainer 1).

### 10.8.3 Workplace factors: Things that helped transfer

The training transfer literature states that major determinants of transfer exist in the workplace (Burke & Hutchins, 2007; Leimbach, 2010). Participants were asked whether anything in their workplace had either helped or hindered them to transfer their learning into practice. Participants used the prompts presented to them, and also cited other factors.

The factor mentioned by most Provider Manager participants (n=6) was the culture of the team towards both safeguarding and learning. One manager went as far as to say that nothing stopped her from applying her action plan which involved team training, because of the enthusiasm of her and her deputy, and the willingness of staff to attend- "I don't think anything really got in our way" (Delegate 2, PM). The support of managers and colleagues was highlighted by many, corroborating past research (Burke & Hutchins, 2007).

Follow up, team meetings, discussion and supervision were highlighted as transfer supports by both groups, and by managers as ways to support their staff apply their learning in practice. Such forums introduced ways to "look at it through that sort of

(safeguarding) lens for a while” (Delegate 2, HuR), and disseminate information through teams.

Another factor that was identified as helpful was taking part in the interview study (Sharples *et al.*, 2003). One person noted that the interview had prompted them to look back through the workbook, while another was more explicit saying,

“Thanks a lot, it’s actually really helpful to go over the material, and talk about how it’s been relevant, coz I wouldn’t have sat down and thought about this if you weren’t asking me” (Delegate 5, HuR)

One delegate, after a conversation about whether training was necessary or sufficient to change practice, began to think about training as a process rather than a solution in itself, demonstrating the Hawthorne effect (Bryan *et al.*, 2002). This may have been a result of discussing transfer in the interview; she appeared to articulate her thought process;

“it needs to be a further step doesn’t there, a next step, you’ve been to your training, then what, there’s more to training than just having your certificate isn’t there” (Delegate 3)

The fact that the interview seemed to provoke such reflection about transfer seems to indicate that the issue is not discussed enough in the sector, while it could be argued that especially in times of austerity it is a crucial discussion to be having in order to ensure that money, time and resources are not being wasted.

#### 10.8.4 Workplace factors: Things that hindered: Provider Manager

Participants were less able to identify factors in the workplace that had hindered them from transferring their learning to practice. Two main issues were communication and

time, perhaps inevitable in a management role. However some people framed time pressures in the context of priority:

“Time as a resource is always precious but safeguarding is really important so it's quite high in the list of priorities, so that's not an issue.” (Delegate 7, PM)

Another related issue was the day job taking over prevented action following training, and how this meant that a clear plan was needed in order for anything to change.

### 10.8.5 Workplace factors: Things that hindered: Human Rights

Factors that hindered Human Rights delegates were different and more extensive and included resistance to change, lack of follow up, staffing issues and pressure of work.

Three Human Rights delegates (who all had supervisory responsibilities) suggested resistance to change hindered transfer; this encompassed staff who were “quite set in their ideas... the sort of people who need the work done on them” (Delegate 10, HuR).

Resistance to change could be manifested as negative comments about new ways of working, which could dissuade staff from persevering with new ideas. Resistance to change is a complex concept and may be influenced by numerous things, one of which is cynicism. The defining characteristic of cynicism has been termed “disbelief in the motives of others” (Stanley, Meyer & Topolnytsky, 2005, :452) and it is “a response to a history of change attempts that are not entirely or clearly successful” (Reichers, Wanous & Austin, 1997, :48). Horwath and Morrison talk about the pace and complexity of change in social care, and how it can lead to insecurity and anxiety which will affect individual and organisational learning in a negative way (Horwath & Morrison, 1999). Therefore attributing ‘resistance to change’ solely to ‘awkward’ staff who need ‘work done on them’ is simplistic, and further analysis of systems is needed.

In the Provider Manager interviews, one person highlighted that “people don't change too easily... but you have to move with the changes” (Delegate 3, PM), and another manager highlighted the importance of competent change management as a skill in managers, which supports the notion that managers should be trained as ‘transfer agents’ (Al-Eisa, Furayyan & Alhemoud, 2009).

Two people mentioned lack of follow up as something that had hindered them transferring their learning to practice.

Staff shortages, or tensions within the staff group were cited as hindrances to transferring learning, as were time and pressures of work;

“I now have no opportunity to do the things I need to do and everything’s a priority... I'm so busy doing I cannot evaluate what I do often... so that is really hindering, the pressure of work in my current role.” (Delegate 4, HuR).

One delegate from a private care home summarised that resources were the main pressure in terms of doing her job well in relation to Human Rights and that this was because “profit doesn’t really mix with welfare that well” (Delegate 5, HuR).

Other factors that hindered transfer were varied, and included having little opportunity to use the learning, the time it takes to change things in social care, a lack of interest (from staff) in learning, and other people's values:

“[it] is quite shocking and upsetting sometimes that you realise people in care in whatever role may still carry poor values, endless frustrations with people who do not understand equality diversity all the other aspects of safeguarding, and I meet that on a day to day basis... and that causes personal concern and concern within our group” (Delegate 4, PM)

The quality of empathy has been noted as an understudied (Gerdes et al., 2011) but desired outcome of social work training (Carpenter, 2005). It could be argued that “poor values” can be traced back to lack of empathy, a quality which is covered in UK social work education but not so much in social care training. Furthermore there is evidence to suggest that service users and carers value staff attitudes over their knowledge and skills, making empathy all the more important (Forrest & Masters, 2004; Forrest, Masters & Milne, 2004).

## **10.9 Barriers to safeguarding**

Although a question about barriers to safeguarding was not specifically asked, the topic arose through conversations around safeguarding adults training. Barriers to safeguarding represent contextual issues which need to be addressed for training to be effective. The main themes are outlined below.

### **10.9.1 Lack of knowledge**

Conversations implied that there is still an unaddressed learning need around safeguarding adults in Cornwall. Abuse is a violation of a person's human or civil rights, and a delegate and a trainer pointed out how very few people are aware of their rights. Other concerns centred on a perception that front line staff do not understand how important it is to make an alert, or how to make one. One person thought that lack of comprehensive training contributed to this:

“if you're not ever told, how would you know so it's about respecting their intelligence to be able to understand those issues so that the care they give is full of respect.” (Delegate 9, PM)

This sentiment was shared by 2 trainers.

Lack of managers' knowledge was also highlighted. This implies one of two things; either that there are barriers to participating in the first place or that the training is being attended, but not transferred. There is some evidence for the latter- a trainer highlighted the problem of lack of knowledge among senior staff, saying,

“you’re thinking here they are on Provider Manager training, they have done Human Rights...or they say they have, but actually either they’ve forgotten it all, they’ve never absorbed it- what does that mean for us in practice, for them in practice?” (Trainer 2)

It is unclear whether there are also barriers to attending safeguarding adults training.

### 10.9.2 Lack of clarity over thresholds and definitions

A safeguarding adults alert should be raised if a vulnerable adult is experiencing or at risk of ‘significant harm’ (Department of Health and the Home Office, 2000). As discussed in section 2.8, this definition is open to interpretation, which appeared to cause some anxiety for managers:

“there are certain things that you have concerns about and think god do I raise this, is this something I should raise? Is this just normal for the family, is this just me... it makes you very unsure” (Delegate 1, PM)

It was also considered a “massive decision” (Delegate 1, PM) to make an alert, and attending the training had prompted reflection on the situations which may indicate that abuse might be occurring. Others expressed frustration that a lack of evidence to support allegations of abuse could hamper decision making about a situation. The ambiguity over thresholds for safeguarding action is a significant issue (Davies *et al.*, 2011; Harbottle, 2007; Killick & Taylor, 2011) and the challenge remains in determining how to provide more clarity to practitioners. Findings from these interviews and a

learning needs analysis (Pike & Royle, 2011) imply that reassurance for managers that they are doing the right thing, through peer discussion and consensus building, may help.

### 10.9.3 Information sharing and multiagency working

The perceived conflict between information sharing and data protection was identified as another barrier to safeguarding. There appeared to be an attitude among some that 'other' agencies were "holding onto information" (Delegate 4, PM), which necessitated further knowledge to quote to "any recalcitrant other agencies that I might have to deal with" (Delegate 8, PM). This barrier appears to come down to a lack of understanding, or a misinterpretation of the existing guidance by 'other agencies', indicating a lack of shared consensus over the practical implications of information sharing guidance. Other barriers noted here include negative perceptions of other professions, different ways of working, and problems with finding the time to collaborate on safeguarding plans. One person voiced concern that "with the best will in the world sometimes you do feel like you are working by yourself" despite knowing that "you shouldn't work alone in safeguarding adults" (Delegate 8, PM). These findings support previous research on barriers to multiagency working, (Penhale et al., 2007; Petch, 2008; Pinkney *et al.*, 2008).

### 10.9.4 Resource issues

Resources were raised as a problem, in terms of the volume of safeguarding alerts overloading the stretched capacity of independent chairs and administrative support. One delegate thought this was due to poor initial assessment of alerts. A trainer highlighted resources as a problem in terms of being able to provide quality care on a

limited budget, but strongly felt that resources were less of an issue than attitude towards people who use services. This sentiment was echoed by another trainer who saw lack of resources as “almost an excuse for that sort of poor practice to continue” (Trainer 2).

From this limited sample it appeared that people who were more aware of the resource constraints were people with more experience of the safeguarding process, and there was evidence that resources are not an insurmountable obstacle to providing a good service.

#### 10.9.5 Perception of safeguarding as negative

The negative connotations of a service being in the safeguarding process were outlined as a further barrier to effective work. The manager of a nursing home described her frustration that others perceived safeguarding as frightening and critical process, and that other professionals would use it as a threat. Likewise, a “sense of caution” was noted over making alerts about other providers of care:

“if I go and do a preadmission assessment on somebody on a hospital ward and... I believe they're being neglected on the basis of my one visit, do I then do a safeguarding alert and how many times do I do that before I get a reputation?... Sometimes there's a moral dilemma about it as well, and I hate to say it a commercial dilemma... I don't think it would take long for word to get around that home keeps making safeguarding alerts” (Delegate 7, PM)

One participant appeared to have the impression that the safeguarding process would mean drastic action, leading to someone being “whipped out of her environment without a by your leave” (Delegate 9, PM). However, another perceived that the safeguarding process takes the pressure off, making it a positive thing, because someone else is dealing with it avoiding any messy internal investigations.



This issue can be related to the transfer literature on the topic of how training is framed. Explaining the remit of safeguarding, the responsibility held by all workers to abide by its principles, and the reality of the process in terms of action taken, before attending the training, may help to make delegates more receptive to learning and transfer of safeguarding adults training. Antle, Frey et al (2010) proposed that attitudes towards controversial topics could be changed by addressing concerns about implementation in training, something that the trainers appeared to have done in the session; however the perception of safeguarding as negative generally remains.

#### 10.9.6 Lack of national consistency

The lack of national consistency when managing safeguarding issues was highlighted by one participant, who held a national post.

“it's very difficult to have a set of policies and procedures when you're working within lots of differently authorities' policies and procedures and believe me they are extremely different across the country- we'll have one authority do a swoop, a morning raid sort of thing... a different authority will sit on the same thing for 3 months” (Delegate 10, PM)

This opinion contrasts sharply to research which found broad similarities between different local authorities' safeguarding policies (Stanley et al, 2011), which implies that although the policies may be similar, resulting practice may not be.

#### 10.9.7 Integrating safeguarding, Mental Capacity Act 2005 and other policies

Perceived conflicts between different policies and legislation were identified as the main barrier by Human Rights attendees. Three people mentioned the complexity of balancing duty of care, choice and mental capacity as a barrier to safeguarding. One person described safeguarding as “like a big soup but you need certain things to be like

a ladder to work your way through it.” (Delegate 4, HuR). People gave examples of situations where people who had been deemed to have capacity were making unwise choices that impacted negatively on their lifestyle or relationships, and the frustration at not being able to intervene. The tension between duty of care and choice was evident in numerous examples:

“safeguarding... has been hindered I suppose by his decision not to make any changes!” (Delegate 9, HuR)

“you think, mental capacity, best interests, my health and safety- usually you end up feeding back to the boss and going what do I do now!” (Delegate 8, HuR)

These sentiments don't necessarily represent a barrier to safeguarding- because of the Mental Capacity Act 2005, adults with capacity can refuse offers of interventions- but do illustrate the difficulties associated with demonstrating the “effectiveness” of safeguarding adults training. This is demonstrated again in the following example, where because a daughter was likely to “just throw us all out” (Delegate 8, HuR) if an alert was made about her mother, the safeguarding process was decided against so carers could continue monitoring the situation and providing some services- arguably a better outcome.

The balance between rights, choice and protection is a delicate one and can conflict with professional duty of care. Informing people of the relevant guidance and legislation appears to trigger much debate over how best to provide services, which can be perceived as a positive outcome.

### 10.9.8 Other barriers to safeguarding

Other barriers to safeguarding were varied. A question was raised over whether the values expressed in policy were always translated into practice, and whether senior managers were always as committed to safeguarding as they claimed.

Making an alert was acknowledged as being difficult, especially if it was about a colleague. One person identified challenging colleagues as “not an easy thing to do” (Delegate 1, HuR), and explained that having been qualified, and in a particular workplace longer made it easier. Having an open culture and discussing practice were seen as facilitators of good safeguarding practice.

Issues with the safeguarding process included the fact that it doesn't always provide clear answers or outcomes, and that there is little opportunity to engage with the “key players” in the process in order to seek advice. Concerns were described about the impact that making an alert might have on a person, as well as a worry about the possible “draconian response” (Collins, 2010, :6) it might evoke.

This was corroborated by a trainer who thought people were worried about getting “into trouble” if they wrongly made an alert (Trainer 3). Respecting staff in terms of pay and training was also mentioned, as well as the challenges of introducing new tools, which could be interpreted as extra work, to a team.

### 10.10 Safeguarding supports

Participants also mentioned a number of factors that helped them to carry out safeguarding adults (and hence transfer training) effectively. A general workplace culture of speaking up and challenging was mentioned as a healthy support to safeguarding.

### 10.10.1 Clear expectations of staff, supervision and training

The issues of staff training and the importance of managers ensuring that their team is aware of safeguarding adults were mentioned. The need to keep reminding people about safeguarding was also raised. One person described how their organisation provided training modules that could be adapted by managers and safeguarding leads to meet the needs of their team.

Approachability so that staff feel able to raise issues was also mentioned as important. Communication methods included a communication book for staff engaged in lone working in a residential setting; supervision and one to one structures; and annual appraisal. Such structures were noted to be important generally, not specifically for safeguarding. Some people did not feel supervision structures were established enough in some areas.

### 10.10.2 Informing and supporting people who use services

Some people talked about discussing safeguarding issues with the people they support. This included talking about their rights, and how to report issues should the need arise, and facilitating people to choose their worker. A complaints process was also mentioned as a way to get people used to the idea of raising issues.

A service identified to be lacking in Cornwall currently, but that would be a help was one that could respond to the needs of adults who had been abused. Although victim support exists for crimes, there is no service for adults who have been through the safeguarding process.

### 10.10.3 Access to advice from experts

Managers seemed to feel reassured by the fact that they could ring up a safeguarding specialist for advice should an incident occur; training had been useful for signposting them to such support. One person who acted as an advisor nationally explained how contacting her was part of the organisation's policy. The role of independent advisors was also valued by an independent provider as “reassuring”, as they had no “vested interest in the company” (Delegate 7, PM).

### 10.10.4 Leadership and management

Strong leadership in safeguarding was also identified as important.

“you've got to live it in your work... if you have a manager of a service who is not adopting the correct values then the whole team tends to not adopt the correct values either and things can go terribly wrong... I think it needs to be reinforced constantly, led by example, good training, good information, a combination of things.” (Delegate 4, PM)

This multi-faceted approach to ensuring good practice is echoed in best practice governance guidance, which recommends addressing all elements in a system (rather than just providing training) (Somerset County Council and Social Care Institute for Excellence, 2011).

It was also suggested that manager training should take priority over training front line staff, as managers can lead and influence their staff. Evidence of impact in terms of communicating safeguarding to staff would tend to support this assertion; notably, the people who did this from the Human Rights course were also managers.

Conversely a lack of leadership, or inability to challenge managers about practice was identified by training as having a demotivating effect around safeguarding;

“often it is around leadership and it is around people on the courses sort of saying that their leaders are poor. Or their leaders are doing the tick boxing or their leaders don’t listen, or what’s the point in filling in an incident form because nothing happens” (Trainer 2)

Again, this highlights the importance of reaching managers to support them to develop a consistent safeguarding culture- “it’s trying to get that overarching message that the organisation supports safeguarding and will support its staff to do as best they can in their practice” (Trainer 1).

#### 10.10.5 Early intervention

Safeguarding was recognised as being a consequence of the failure to intervene early enough. Early intervention and more investment in care, as opposed to crisis care, was advocated as a way to prevent safeguarding situations.

#### 10.10.6 Other safeguarding supports

Other supports raised included having paper based tools to record any potential signs of abuse and having a multidisciplinary network to contact with safeguarding issues, so that

“I’d immediately know where to go... and even if I rang the safeguarding team and the DOLS team, they would be able to refer me to the right place”  
(Delegate 5, HuR)

Another person noted that information sharing and multiagency working was becoming easier, and more frequent. Other supports included the prevalence of safeguarding related issues in the media, and the prioritisation of safeguarding issues in the home.

## 10.11 Conclusions

The 23 interviews revealed that some substantial impacts have occurred as a result of the training, though the Provider Manager training had more wide ranging and specific impacts than the Human Rights workshop. Antecedents to practical outcomes appeared to be mainly knowledge and confidence gain, with skill acquisition and attitude change mentioned less frequently. Attending the training in pairs had a supportive effect in terms of creation and implementation of action plans.

As well as determining the impacts of training, the analysis examined factors relevant to the development of the programme theory of safeguarding adults training. Mandating training appeared to affect the training motivation of different levels of staff in different ways. While managers readily identified a learning need as well as a requirement to attend, more junior staff tended to identify requirement as the main reason for attending, which was accompanied with some cynicism about the training culture. No participants mentioned a performance deficit as a reason for attending. Learning needs analysis was identified as an important mechanism to develop intrinsic motivation to attend.

The training appears to take account of the principles of adult learning and training transfer, and adhering to these principles constituted a critical factor for transfer. However the transfer climate described by participants was not always supportive of the use of tools such as preparation and action plans, which can facilitate transfer. Follow up appeared necessary for action plan implementation, and also contributed to the perception of training being valuable and effective.

As well as the transfer climate, structural supports and barriers to safeguarding were discussed in some depth. Although some barriers to safeguarding, such as lack of

knowledge or poor values, may be addressed through training provision, there were numerous other factors, such as resources, multiagency working, leadership and management in safeguarding, and the perception of safeguarding as negative that need addressing through methods other than training. The 'safeguarding climate' as well as the transfer climate is an important factor to consider in the implementation of safeguarding adults training. The following chapter integrates these findings with those of the factorial survey to develop the third and final iteration of the programme theory of safeguarding adults training.





## Chapter 11 Synthesis of empirical findings

This chapter will synthesise the findings of the factorial survey with the findings of the narrative analysis, using the framework of the second iteration of the programme theory. This will result in an amended programme theory specific to safeguarding adults training, rather than health and social care training in general. The causal propositions are used here as headings, under which to structure the synthesis of the data. The programme theory is the normative, or ideal version of the theory, and aims to outline what works, for whom, in which circumstances and how.

### 11.1 Causal propositions contained in the second iteration of the programme theory

Training being mandated causes organisations to conduct learning needs analyses of their staff to determine the cause of the performance deficit.

A learning (or training) needs analysis acts as a mechanism to enable the identification of training needs of the workforce, and prioritise the training that should be provided (Horwath & Morrison, 1999). When training is mandatory, this process is in part negated, as safeguarding training will be provided regardless of the outcome of the analysis. This epitomises the tension between the requirements of organisations, and the needs of individuals in terms of learning (Horwath & Morrison, 1999). While the mechanism of learning needs analysis is not adhered to in its pure form, elements of it are important to retain in the safeguarding adults training process.

All staff appeared to be in agreement that safeguarding adults was a priority; this was reflected both in comments made in the interviews, and the high recognition and reporting scores observed in the factorial survey. Mandating the training may have contributed to this. Participants in the interview study noted another factor that

caused the prioritisation of attending; the requirements of professional bodies that their members attend a specified number of hours of training each year.

Perhaps because of this perception of safeguarding as a priority, managers in particular talked about the need to understand the process of safeguarding, for themselves as managers and to pass on to staff. It is possible that mandating training works as a mechanism to make attending more of a priority, because of the strong messages from various authorities that safeguarding is a key component of people's work. This prompts a learning needs analysis where people compare their own skills to those needed for safeguarding adults to work, which may be formal or informal. So mandating training does prompt a learning needs analysis to be carried out, but indirectly through raising safeguarding as a priority.

### [Conducting a learning needs analysis results in the right people attending training](#)

Conducting a learning needs analysis is important to ensure that people are motivated to attend because the training is relevant to them, which in turn leads to the right people attending. It can also contribute to the design of training, though there was no evidence that that had happened here, and identify the cause of a performance deficit. Policy would argue that all staff and volunteers should attend training, while the second iteration of the programme theory defined the 'right people' as people who attend to meet a learning need, and have workplace support and sufficient notice to attend.

Motivation to attend is an important construct identified in the transfer literature that should be included in the safeguarding adults training model too. Its antecedents appear to be wide ranging, and include the identification of learning need (an intrinsic

motivation), but also, as mentioned above, requirement (an extrinsic motivation). Trainers suggested that if people were not compelled to attend through the training being mandatory, they probably wouldn't attend at all because there is not a culture of seeking out training to address learning need. Motivations to attend from requirement seemed to come from a number of perceived sources; organisational policy, legality, recommendations to attend from the Care Quality Commission, and pressures to meet professional training requirements. This shows that currently a mixture of intrinsic and extrinsic motivation leads to attendance on safeguarding adults training, although there is evidence that intrinsic motivation is more likely to result in transfer (Burke & Hutchins, 2007); perhaps because it is a principle of adult learning (Knowles, 1990).

However for managers, the extrinsic motivations may be tempered with some element of choice and control over attending. This may be important to resolving the mandatory training-adult learning conflict (Mythen & Gidman, 2011); managers were not 'sent' on training, which lessened the chance of resentment of their self-direction and control being taken away, and consequently improved their motivation to attend and learn. For managers it appears the numerous cues regarding the importance of safeguarding work positively to motivate them to attend, as they were able to come to the realisation that they would benefit from the training themselves.

The preparation also contributed to some delegates' motivation to attend, in terms of taking attending more seriously, understanding the purpose of attending and the relevance to the job, and having clearer expectations of what the training was meant to achieve. However the value given to training through the training culture affected perceptions of the preparation work.

Human rights delegates, in particular people in less senior roles, were more likely to describe being 'sent' on training, and less likely to perceive their reason for attending as to meet a learning need. This negatively affected motivation and led to cynicism about attending, exemplified in the comments made about training being a tick box exercise. The literature review showed that motivation to attend and transfer is likely to be higher if a learning need has been identified and discussed with the delegate. While mandating training is effective at getting people to training (even though this may be reluctantly), giving people the autonomy to choose when to attend after comprehending why they need to is likely to provide a more positive start to the session, as evidenced by the trainers' perceptions of the positive impact of preparation. The evidence supported the proposition that conducting a learning needs analysis results in the right people attending training, though motivation to attend was also influenced by other factors.

Regarding the other criteria of the 'right people', adequate workplace support and sufficient notice to attend, no one specifically mentioned the issue of notice to attend as being a problem, although some people did talk about being told they were attending, and not receiving the preparation work. Workplace support was identified as important to transfer, and is discussed in more depth later on.

[The identification \(via the learning needs analysis\) of a knowledge, skill or attitude gap, or interpersonal/ team issues leads to safeguarding adults training programmes being devised.](#)

No additional data was gained from this study about whether the identification of a knowledge, skill or attitude gap, or interpersonal/ team issues leads to safeguarding programmes being devised. While it is possible that policy and performance are the

drivers for devising programmes in the sector, the transfer literature suggests learning needs analysis is causally related to transfer (Burke & Hutchins, 2007; Chow, Woodford & Showers-Chow, 2008; Taylor, Russ-Eft & Chan, 2005) so this mechanism will be retained in the model. Furthermore, the learning needs analysis allows training providers and organisations to focus on the aspects of safeguarding that staff are struggling with.

Training programmes being devised leads to trainers delivering programmes that take account of a) the principles of adult learning b) the principles of training transfer

There was evidence that the principles of training transfer and adult learning are adhered to in the design and delivery of the safeguarding adults training courses evaluated here. Relevance was noted as an important determinant of transfer, and a principle of adult learning. Participants cited discussion, group work, case studies, and hearing other people's experiences as aspects of the workshops that reinforced relevance. Structures such as preparation and action plans supported adult learning and transfer, but only where the transfer climate was supportive of their use; this is discussed later on. The inclusion of a follow up session in the structure of the training was important to ensuring that action plans were carried out, but only the manager programme included one.

Providing follow up to the large numbers of staff that attend introductory safeguarding adults training has significant resource implications for training providers. However the inclusion of follow up was shown to both increase the value of training, by making it seem more worthwhile, and also to lead to training outcomes, implying it is an investment worth making. Some delegates acknowledged that the training provider is

not the only party responsible for transfer, and that organisations should provide follow up and supervision to support training implementation. Follow up structures are recommended in the transfer literature, and appear to be important here too.

Other authors (Bennett *et al.*, 2007; Buckley, 2000) have noted that while training providers may design transfer and adult learning supports into programmes, delegates may not always use them. The interview study showed that many participants felt that preparation was an extra administrative task, or yet more paperwork, and without follow up they felt the same towards action plans- the implication is that people do not have the time to prepare for, or follow up training. However other participants, talking about safeguarding generally, said that time was not a barrier because safeguarding is a priority; arguably this approach can be applied to any work task. Findings, along with previous research can be interpreted to show that using transfer supports is not a priority in health and social care, which is likely to reflect the transfer climate. This means that although training providers are trying to promote transfer through including structures such as action plans and preparation, their efforts are unlikely to be effective until the transfer climate becomes more amenable to using them.

As well as adult learning and transfer principles, trainer credibility and confidence were also perceived by participants to be important to transfer; this has been identified in previous health and social care training research (Gauntlett, 2005). Credibility of the trainer may help to counteract the cynicism of delegates towards the transfer climate; delegates gained confidence from the trainers' confidence.

Using other Human Resources procedures to address some interpersonal or team issues, or lack of ability in the job, leads to changed practice.

Little evidence was obtained to support or refute this proposition. One person raised a concern about the values that some people in the sector have, and how those values do not always correspond to the values necessary to safeguarding adults (such as respecting human rights (Commission for Social Care Inspection, 2008a) and promoting respect, independence, dignity and choice (ADSS, 2005). The question of whether values can be changed through training, and whether particular values are necessary to effective safeguarding adults work, is one that warrants further attention. In a safeguarding adults context though, the right value base might be one interpretation of ability to do the job, and should consequently be selected for at the recruitment stage.

When the right people attend training that takes account of the principles of adult learning and training transfer, skills are learned, confidence increases, attitudes are changed and/ or knowledge is gained.

The results of the factorial survey and the qualitative analysis do not appear to match up with regard to this issue. The factorial survey showed that level of training attended had no impact on recognition or reporting of abuse, which equates to knowledge of when abuse is happening and when an alert should be made. Other factors such as participants' past experience of safeguarding, past experience in their job, and factors contained in the situation impacted on recognition and reporting of abuse while training did not. In contrast, the interview study showed that participants could describe a number of impacts that were contributed to by an increased knowledge of safeguarding.



The difficulty in quantitatively assessing whether training has had a positive effect stems from the problem of assessing the accuracy of a threshold judgement. If training is meant to increase all recognition and reporting, regardless of accuracy (which could lead to an increased number of alerts which are not judged to address a safeguarding issue and therefore do not enter the process) then a straightforward relationship between training and alerting could be expected, in that trained people will be expected to alert over any situation that has the slightest hint of abuse. This is the approach taken here; that higher levels of training should lead to higher recognition and reporting of abuse, almost regardless of the situation. However the view expressed by some more experienced practitioners in the interview study, was that the safeguarding system is oversubscribed with work that should be addressed through care planning. It could therefore be argued that the better trained and more experienced practitioners will be more able to make a more informed judgement about risk, as well as having a better understanding of the appropriateness of entering the safeguarding process in terms of improving outcomes. This may lead to lower recognition and reporting of abuse, and could explain the apparent lack of linear relationship between training and recognition and reporting of abuse.

Self-efficacy, or confidence, is a well-established antecedent of transfer (Blume *et al.*, 2010; Burke & Hutchins, 2007) and has been also demonstrated as a training outcome (Combs & Luthans, 2007; Pattni, Soutar & Klobas, 2007; Taylor, Mesmer-Magnus & Burns, 2008). In the factorial survey an increased level of training had a negative impact on confidence in ratings; as people attended higher levels of training, their confidence in their choices of action diminished. However when training and length of time in the job was combined in an interaction variable, a positive relationship was

observed with confidence. From the qualitative analysis, the higher level of training (Provider Manager training) led to more reports of increased confidence in their safeguarding skills and knowledge. It is possible that the factorial survey did not provide a valid measure of training level; this is discussed further in section 12.4.2. An alternative explanation is that the factorial survey provided a measure of the impact of training on its own, which, without opportunity to practice new skills, does not lead to increased confidence or changed practice. The provider manager training included follow up, and a month of opportunity to practice skills for delegates; this may explain the discrepancy and also explains similar findings from previous research (Ford, Bammer & Becker, 2009).

Furthermore, practitioners with more total experience working in health or social care recorded lower confidence levels, while practitioners with more experience working in their current workplace noted higher confidence. This was echoed by one interviewee who said working in the same workplace for longer made whistleblowing easier. Length of time in current workplace may lead to increased confidence because of familiarity with policies, procedures and culture around safeguarding. However there were high levels of correlation between the demographic variables collected in the factorial survey, so further research on what makes a confident safeguarding adults practitioner is recommended.

The discrepancy in findings concerning confidence in the factorial survey and qualitative data may also be explained by the concept of unconscious incompetence (Chapman, 2010). Factorial survey participants who had attended no, or low levels of training might not have appreciated the complexity of safeguarding, and so had false confidence in their actions. The qualitative interviews support this hypothesis, as a

number of people mentioned that the training had led them to consider the other issues (such as mental capacity) that interlink with safeguarding more closely, and that it could be difficult to know what the best course of action to take is. This means that training could have the effect of decreasing confidence temporarily, while new knowledge is assimilated into practice. Opportunity to use that new knowledge, and discuss it with others increases it. This could explain why managers' confidence generally increased; they had a half day follow up session to discuss concerns from the first session.

Confidence is a complex construct, affected by numerous things including training and demographic factors, but also situation being responded to. Confidence in recognition and reporting scores was increased by situational factors including more severe abuse, the alleged victim not liking the alleged perpetrator, and a disclosure from the alleged victim. This implies that people's confidence is higher when the abuse is clearer, making the course of action they should take clearer. Previous involvement in safeguarding also positively affected confidence in decisions.

Arguably the qualitative analysis provides data that is more representative of the impact of training, because of certainty over what was attended, and in what form, and the rich nature of the data. The proposition is supported by the qualitative data, as confidence was increased and knowledge gained, though there was limited evidence of attitude change or skill gain.

[Newly learned skills, increases in confidence, changes in attitudes and / or knowledge gains lead to changed practice.](#)

Gains in knowledge, confidence and skills, and changed attitudes were considered antecedents to transfer in this study, rather than outcomes of training in themselves.

As highlighted above, the relationship between training and confidence is complex and may be negative without subsequent opportunity to use and workplace support. However both the factorial survey and the interviews found that confidence was positively linked to recognition of abuse and other safeguarding adults related actions. Participants in the interview study explained how confidence was associated with a propensity to act, whereas before, they might not have taken any action through not being sure they were right. In a subject like safeguarding where thresholds are both unclear and affected by numerous factors (Harbottle, 2007), confidence to act is crucial to ensure that abuse does not go unaddressed.

New knowledge similarly led people to take action, such as signposting their staff to appropriate safeguarding resources, changing their practice with service users, or raising situations as safeguarding that they wouldn't have previously. Changed attitudes may have contributed to changed practice when working with people who use services, and new skills, though bordering on knowledge also led to outcomes - for example a manager and her colleague trained their staff in safeguarding after receiving materials from the trainers and observing their training techniques. Knowledge, confidence, skills and attitude changes or improvements can be considered antecedents to transfer in safeguarding adults practice.

[Cohort attendance on training leads to shared learning and peer support, which results in changed practice when the principles of training transfer are applied in the workplace.](#)

There was some evidence of support for this proposition from the qualitative interviews, which corroborates the more comprehensive findings of the systematic literature review and realist synthesis. The concept of 'critical mass' was raised in the

literature review as aiding transfer (Gauntlett, 2005), as support to use new skills and knowledge is gained from other people trying to achieve the same thing. A similar mechanism of support was observed in the safeguarding adults training context.

These causal relationships are moderated by the presence or absence of structures to support new learning, resources available to support training and transfer, and the transfer climate as well as the reason for the performance deficit that necessitated training.

The qualitative interviews highlighted a number of factors related to the transfer climate that help transfer, including a positive team culture (in terms of supporting the implementation of action plans), follow up, team meetings, discussion and supervision, supportive managers or colleagues, time to reflect, openness to change, and resources to support transfer. These can all be related to the proposition in that they are workplace structures that have the potential to support new learning. Things that hindered transfer could be classified as the absence of structures and resources to support new learning, such as lack of time and resources, pressure of work or staff shortages or tensions, or a negative transfer climate which results in resistance to change and lack of follow up. A negative transfer climate, where training was not valued, also inhibited the use of transfer supports such as action plans and preparation.

Opportunity to use new learning was identified as another contextual factor that moderated transfer. Interview findings corroborated findings from the literature review, but enabled the interpretation of them in a way specific to safeguarding adults. Opportunity to use was not primarily lacking due to the usual workplace constraints of time and resources (Gauntlett, 2005; Zweibel *et al.*, 2008), but because a safeguarding situation did not arise. While this is a positive outcome, it raises the question of how

safeguarding skills can be kept 'refreshed'; the answer may lie in the 'safeguarding climate', relating to how often potential safeguarding issues are discussed. By facilitating an open dialogue about practice and potential safeguarding situations, opportunities to use the knowledge and skills developed in training can be provided. Another contextual factor mentioned was having the autonomy to act, which is related to opportunity to use.

As well as barriers to training transfer, barriers specific to implementing safeguarding adults were also discussed; these also constitute barriers to safeguarding adults training transfer. Lack of resources was mentioned, and different elements of resource deficit were identified; some in the safeguarding system, in terms of capacity to arrange meetings that adhered to timescales, and others in terms of providing good quality care on a limited budget. The negative perception of safeguarding and challenges of whistleblowing and multiagency information sharing were also raised as barriers to safeguarding by some, as was the complexity of integrating safeguarding with mental capacity and other legislation and policy in practice. While training can address some of these issues, other strategies (such as supervision, reviewing resources, and considering ways to facilitate multiagency information sharing) will also be needed to address the safeguarding climate in its entirety.

Other people's poor values were mentioned as being a barrier to safeguarding, which raises the question of whether the appropriate human rights value base can be taught, or if other procedures such as recruitment and selection would be more effective. Some studies have found that medical staff's attitudes to older people have been improved through interventions (Gonzales, Morrow-Howell & Gilbert, 2010;

Westmoreland *et al.*, 2009) but it remains to be seen how this could be translated to a social care context.

Safeguarding supports (which consequently facilitated transfer) encompassed numerous issues not specific to safeguarding, such as clear expectations of staff, supervision and training, access to advice from experts, leadership and management, and early intervention. The need for additional management support and development was highlighted, including by the trainers who noted that training often addressed management, rather than safeguarding issues. Some people (but not many) discussed informing people who use services about safeguarding as a safeguarding support. While this is positive, it implies some attitude change is still needed concerning the promotion of empowerment and self-protection, something which is necessary in the context of personalisation (Braye, Orr & Preston-Shoot, 2011b).

The factorial survey showed that the actions taken in a safeguarding situation are also influenced by the characteristics of the situation itself, such as the type and severity of abuse (Killick & Taylor, 2011), the perceived support from management and the organisation, the type of abuse, and whether the alleged victim had disclosed abusive behaviour. Therefore there is a safeguarding specific element of a model of safeguarding adults training transfer, where the situation that delegates are managing impacts on the degree to which they transfer their knowledge into practical action. Furthermore the interviews revealed that even when abuse is recognised, it may not be reported due to the challenges of reporting a colleague, the perception of safeguarding as oversubscribed, or the perception that it could lead to family disengagement with the service. Again this highlights the role of contextual factors in training transfer.

The interview data shows that factors specific to safeguarding adults practice affect the transfer of safeguarding adults training and consequently, safeguarding supports and barriers to safeguarding need to be included as contextual factors in the programme theory of safeguarding adults training effectiveness.

### Impacts: Changed practice (training transfer)

The impacts of a combination of training, opportunity to use and workplace supports are wide ranging and varied; necessarily so, because each workplace and delegate is different. Impacts ranged from a deeper consideration of the issues surrounding safeguarding, and whether safeguarding should be taken forward, to dissemination of information to staff via induction, supervision and training. Some people described changes to how they worked with people who used their service, by upholding their human and civil rights. Policies and procedures were amended in some cases, staff had made efforts to work in a more multiagency way, and staffing or human resource issues had been addressed. These are the positive benefits of training where transfer had been supported; other people, who either did not feel that anything in their workplace needed changing, or lacked support or opportunity to use their learning, reported limited impacts.

Figure 25 presents a final model of the programme theory of safeguarding adults training. Solid arrows represent causal relationship, and dotted arrows represent correlations. Some relationships are mediated by contextual factors, which are indicated on the diagram in purple.



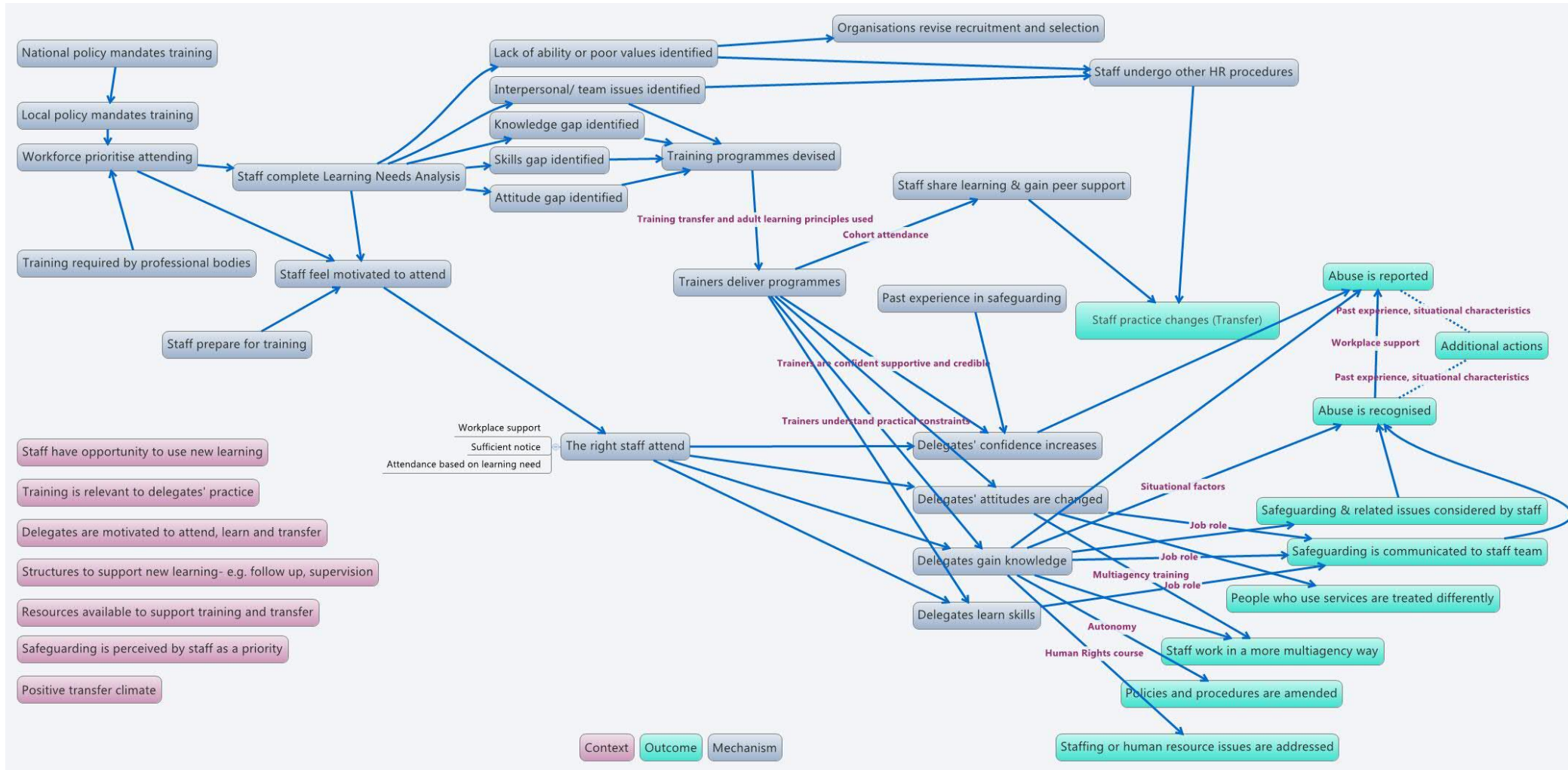


Figure 25: Final iteration of the programme theory of safeguarding adults training.

## Chapter 12 Discussion

This section will discuss the results in relation to the research questions, relating findings to the existing literature. Limitations of the study and the extent to which the findings can be generalised will then be discussed. Finally, implications for future research will be outlined.

### 12.1 Answers to the research questions

The resulting cross sectional, mixed methods study provides answers to the following research questions.

1a) What are the factors that are known to influence training transfer generally, and more specifically in social care?

The findings of previous literature reviews were confirmed and updated. Baldwin and Ford (1988)'s model of transfer, encompassing a triad of factors (individual characteristics, training design and delivery and workplace factors) were supported as a useful taxonomy for transfer research both generally and in health and social care training.

In terms of individual characteristics, cognitive ability, self-efficacy and numerous types of motivation were found to have a strong or moderate relationship with transfer. Some types of personality characteristics also have a moderate relationship with transfer, corroborating previous findings by Burke and Hutchins (2007). The review identified a number of factors that influence transfer additional to those identified by Burke and Hutchins, including goal orientation, learner readiness, attitude

to training and to the topic, and demographics. In terms of social care training, motivation was an important factor, and this was influenced by numerous contexts and mechanisms including learning needs analyses, the predominant transfer climate and priority afforded to attending training, and feeling prepared for training in terms of understanding the relevance to the workplace. While self-efficacy has not been explored as an antecedent of transfer as extensively in the health and social care literature as in other transfer literature, the confidence of staff appears to be an important prerequisite to training transfer. Confidence acts as a mechanism that promotes the desired outcomes of training (such as reporting of abuse) in the context of a supportive workplace. The ability to achieve “far transfer”, where concepts and principles, rather than prescribed processes are applied to work was also identified as an important transfer antecedent for health and social care staff, though the design and delivery of training has the potential to support this trait.

Findings concerning intervention design and delivery corroborated previous findings that learning goals, content relevance, and practice and feedback were all positively related to transfer. Some evidence was found to support the relationship between transfer and needs analysis, active learning, and self-management strategies. Additional factors identified in this wider search included some qualitative evidence of the effectiveness of peer coaching in relation to transfer, and the impact of trainer characteristics on the credibility of training and subsequently transfer. Relating to health and social care training transfer specifically, the principles of training transfer and adult learning were identified as important to adhere to. Content relevance and trainer credibility facilitated transfer, as did structures identified in the wider search, including practice and feedback opportunities, and follow up. Management and

organisational buy in using follow up structures post training was identified as helpful to ensure that transfer design features were utilised; without this, time and work pressures often resulted in lack of use of transfer supports.

Regarding workplace factors, in the wider search evidence was found to support the link between training transfer and transfer climate, supervisory support, peer support, and opportunity to perform as mentioned in Burke and Hutchins' review. Some support was found for the importance of having a strategic link between organisational goals and training goals, but no additional evidence was found concerning accountability despite Burke and Hutchins' call for evidence on this topic. Additional factors identified included evaluation of training as a prompt to transfer, performance feedback, and the impact of wider contextual factors. In the social care search, these findings were corroborated; a positive transfer climate, supervisor and peer support, follow up structures, and opportunity to use training were all important. Furthermore structural supports specific to safeguarding were identified as helping safeguarding adults training transfer, as well as other programmes in the social care search. As well as the transfer climate, the 'safeguarding' climate- cues to staff regarding attitudes and resources, which relate to how seriously safeguarding is taken in the workplace- can either help or hinder safeguarding adults training transfer.

1b) What practical recommendations follow from these findings?

See section 12.3 for details of practical recommendations resulting from the study as a whole.

2) What effect do the Human Rights workshop and Safeguarding Adults Managers' workshop have on delegates' practice, in terms of

- a) thresholds to recognising and reporting adult abuse
- 2b) actions undertaken in the workplace as a consequence of attendance on the workshop
- 2c) Considering the findings of a) and b), does the Manager's training add anything (in terms of actions taken or thresholds to recognising and reporting abuse) to the effect of Human Rights workshop?

Results from the factorial survey showed that training on its own had a negative impact on confidence, and no impact on the recognition or reporting of abuse. However when combined with length of time in current job, training had a positive impact on confidence. The transfer literature shows that providing delegates with opportunity to use training is important for the transfer of learning to practice, and the same applies to safeguarding adults training. Although training had no impact, other factors including demographics, experience and factors in the vignette scenario did impact on recognition and reporting of abuse.

However the qualitative interviews showed that a wide range of actions had been undertaken in the workplace following both types of training. Increase of knowledge, confidence, and skills and change in attitudes were described as mechanisms facilitated by the training that led, in conjunction with workplace supports, to actions. For the Provider Manager group, actions included a variety of ways of communicating safeguarding to staff teams including providing training to them, impacts on multiagency working, reporting abuse following the encouragement of alerting, updating or amending policies and procedures around safeguarding, and impacts on people who use services. For human rights attendees, impacts included positive changes towards practice with people who use services, reporting abuse or following up on safeguarding alerts already made, and human resource or staffing related

impacts. Five people from the Human Rights workshop said it had had limited impact on their work. Trainers were able to provide some extra information, saying they had no idea about the impact that the Human Rights workshop had, but felt well informed about the breadth of Provider Manager impacts due to the follow up day. Impacts varied in scale, scope and ambition, from probably nothing to affecting national policies.

Both courses promote far, rather than near transfer, but the Provider Manager workshop appears to equip managers with the knowledge and skills to improve the management of safeguarding in their organisation, as evidenced by changes to policies and procedures, and communicating safeguarding adults to staff. Managers' impacts tended to be wider ranging and more specific, which reflects the practical, task based and manager focussed nature of the training. The Human Rights attendees' impacts focussed more on awareness and impacts on, and consideration of the views of people who use services, which related to its focus on principles and getting delegates' 'radars' working with regard to identifying human rights and safeguarding related issues. Put together, workers should have a better radar, and managers should be able to facilitate its use by providing them with the optimum environment in terms of structures in which to perform safeguarding behaviours. The range of impacts show the difficulty in defining what the outcome of training should be, as it is specific to individual providers.

It is difficult to say for certain whether the difference in impacts was due to the course, or the demographic that each course was aimed at. It is worth noting that seven of the ten Human Rights workshop participants held a managerial or professional post, implying that the course may have had more of an influence. Managers' training is

more role specific and targets a narrower group of people, meaning it has more potential to translate into practical changes.

3) What factors in the workshops or workplace act as facilitators of or barriers to the transfer of learning from the workshop into practice?

Numerous factors identified in the transfer literature as facilitating (e.g. supervisor and peer support (Burke & Hutchins, 2007; Stolee *et al.*, 2009) and follow up (Killick, 2005)) or hindering transfer (e.g. lack of opportunity to use (Gauntlett, 2005; Meyer *et al.*, 2007)) were corroborated by the findings of the empirical research.

Finally, the variable “support” which combined factors of organisational and management support of whistleblowing in the factorial survey showed a weak, positive relationship with recognition of abuse. It is likely, as the method measures the hypothetical rather than the actual, that the effect of culture on recognition and reporting is greatly underplayed, and it is notable that it has an impact even in such hypothetical situations. The “Support” variable also had a positive predictive relationship with reporting, which indicates that people are more likely to report when supportive structures are in place (even hypothetically). This, along with the evidence from the literature review on safeguarding adults practice in Chapter 3, the evidence on the importance of support to training transfer from the wider, and health and social care specific transfer literature, and the qualitative analysis implies that support is paramount in ensuring the use of safeguarding adults related learning in practice.

## **12.2 Contribution to knowledge**

This study elucidates the mechanism of action by which safeguarding adults training works, showing the processes specific to the topic framed within the wider training transfer literature. This has not previously been done. While the need for safeguarding adults training evaluation has had widespread recognition (Department of Health, 2009a), the existing and limited research generally measures either learning (Richardson, Kitchen & Livingston, 2002) or behaviour (Dementia Services Development Centre, 2010) as an outcome. This study goes further by examining the mechanism of action by which safeguarding adults training is effective, and producing a normative model or programme theory. This could be developed into a tool for practitioners to use, in order to begin to change the culture of training in the sector.

The study also is the first, to the author's knowledge, to use a factorial survey to measure the impact of training.

## **12.3 Implications for policy, practice and training**

The revised version of the programme theory shown in Figure 25 elaborates on and develops the assumptions contained in the initial policy makers programme theory, articulated in Figure 3. In particular, the part of the implementation chain termed 'delegates transfer learning to practice' in version 1 has been unpacked, to reveal a number of mechanisms and contextual features important to safeguarding adults training transfer. Knowledge, confidence and skill gain and attitude change were identified not as outcomes in themselves, but as mechanisms that result in transfer outcomes given the appropriate context. The influence of job role, the characteristics of the situation being responded to, past experience, the type and content of training and autonomy were outlined as mediating the relationship between these preliminary



mechanisms and transfer. Contextually, workplace support in terms of both training transfer related structures and safeguarding adults were identified as important to transfer.

While the initial programme theory postulated mechanisms that could result in transfer, the final model links mechanisms supported by the empirical evidence and the transfer literature into causal chains to produce a normative model. The importance of some of the mechanisms proposed in policy, such as shared knowledge, and meeting people's learning needs were supported by the evidence. However others, such as 'informing people of all possible actions to undertake in a safeguarding situation' were not. Furthermore the resulting programme theory provides a model that can be tested and developed with future research, whereas before the policy model was implicit but poorly defined. The outcomes of training have been expressed with more specificity, although they relate only to the training carried out in Cornwall.

The findings from this study suggest that to maximise safeguarding adults training transfer the following recommendations should be considered.

Recommendations for policy makers, sector led organisations (e.g. Skills for Care) and the Care Quality Commission

- 1) The issue of training transfer should become a key focus for policy makers and regulators who emphasise the role of training in implementing strategy (Department of Health, 2009b; Skills for Care, 2011a). Top down strategies, such as changing the way providers are inspected from process focussed (have staff attended training) to outcome focussed (what impact has training had) assessment, combined with the bottom up structures listed below may impact on the degree of transfer of training in the sector.
- 2) Policy makers, sector led organisations and regulators should promote the value of training transfer- related structures to influence organisational practice in safeguarding adults.

### Recommendations for organisations providing care services

At a more local level, efforts should be made to change the training culture, where training currently is perceived by many to be a tick box exercise. Implementing the following recommendations should begin this process.

- 1) Organisations should take steps to ensure that the transfer climate, a major determinant of transfer, is positive. By assessing the climate using a validated tool, deficient areas can be addressed by putting the appropriate structures in place. Structures influence the climate by providing employees with cues that training is valued and expected to result in transfer.
- 2) Organisations should ensure that the appropriate safeguarding adults related structures (e.g. access to 'experts' for advice, advocacy for people who use services, whistleblowing policy, induction, supervision and team meetings including opportunities to discuss safeguarding issues) are in place to support the new knowledge and practices that staff attempt to transfer from training. Safeguarding adults and related practice should be promoted as a priority. Training and supporting managers of services to amend existing structures and influence staff attitudes around safeguarding will support the development and use of such structures.
- 3) In keeping with the principles of adult learning, as much autonomy, choice and control as possible should be afforded to learners concerning the safeguarding adults related learning and development that they undertake, within the constraints of 'mandatory' training and service requirements. Training should be framed in terms of performance and service improvement, rather than to meet a generalised 'requirement'.
- 4) Delegates' motivation to attend can be enhanced by using tools such as learning needs analyses and training preparation to ensure that the relevance and purpose of attending is understood.
- 5) Following attending training, delegates' confidence in safeguarding should be consolidated through providing them with the opportunity to use new knowledge and skills, and receive constructive feedback and support regarding their performance.

### Recommendations for training providers

- 1) The principles of adult learning and training transfer should be adhered to in the design and delivery of training. Content should be based on learning needs analyses where possible.
- 2) Trainers should be credible (i.e. with experience of front line safeguarding practice), convey a good understanding of the practical constraints- and approaches to work effectively within those constraints- of applying learning in practice, and have confidence in the safeguarding process. They should

facilitate debate and discussion, and enable learners to link their learning to their practice.

- 3) Follow up should be designed into the training, or provided in the workplace; this should provide opportunities for learners to check and reflect on their practice relating to the aims of the training.

Recommendations for organisations and training providers to consider jointly

- 1) The appropriateness of cohort training compared to multiagency training should be considered in relation to the job role of the delegates attending and the aims of the training.
- 2) Supervisors should be provided with learning and development, where necessary, around their role as a transfer agent, and the importance of supervisory support to training transfer. Supervisory structures that include support of training transfer should be initiated.

In addition to this, rigorous recruitment and selection procedures are necessary to ensure that the workforce comprises people with the right attitudes, values and abilities to carry out safeguarding adults work.

A number of recommendations can also be made about safeguarding structures that could be put into place to maximise prevention and detection of abuse. The factorial survey showed that a disclosure by the alleged victim that the alleged perpetrator had hurt them resulted in higher levels of recognition and reporting of abuse. This has implications for practice in terms of providing opportunities for people who use services to disclose abuse they may have experienced (Northway *et al.*, 2004). If a disclosure makes recognition of abuse more likely, more opportunities to disclose should be made available. It also highlights the importance of advocacy services for people who may not be able to disclose themselves, due to communication or other impairment (Calcraft, 2007). One possibility for measuring the effectiveness of safeguarding adults training in the future would be to emphasise the importance of

advocacy, opportunities for disclosure, and informing people who use services about the structures they can use to report any harm they may be experiencing in training, and monitor whether corresponding structures are affected in the workplace as a result.

Finally, the threshold to action in safeguarding is acknowledged as a grey area which can be influenced by numerous factors (Harbottle, 2007). Interviewees mentioned lack of clarity around thresholds being a barrier to safeguarding, and this was supported by the factorial survey which showed that people's confidence in their actions was higher where abuse was more severe. Furthermore, the perception of safeguarding as negative was also seen as a barrier to reporting. This implies that more support should be provided around threshold judgements, as well as encouraging a culture where questioning whether a situation is safeguarding is seen as a positive, rather than a negative thing. Facilitating discussion around practice is an important aspect of a learning culture, and openness to challenging practice can benefit people who use services.

## **12.4 Critique of the research methods**

The limitations of each method are discussed in the Methods chapter, and recapped below. However, when taken together, despite individual failings the methods comprise a robust design, taking account the circumstances.

### **12.4.1 The 'ideal' method vs. reality**

An ideal research design would involve a randomised controlled trial, consisting of pre, immediately post and 6-9 month post training measures of safeguarding adults training transfer, both quantitative and qualitative. It would involve participants from a

range of health and social care providers of varying quality, and with varying levels of engagement with training and safeguarding. A number of reliable and valid quantitative measures would be administered to measure factors such as learner characteristics, motivation to transfer, transfer climate, training transfer, attitudes towards people who use services, frequency and severity of abuse, and outcomes for people who use services. Qualitative measures would provide open and honest accounts of the impact of training on safeguarding behaviours and abuse levels, and the impact that training had had on both personal practice, and the performance of the organisation. Ideally, people who use services and their carers would also be involved in the evaluation, in order to triangulate the views of delegates, their managers, and training professionals.

In reality, the constraints of resources and time, in terms of the research, and the context of health and social care, in terms of workplace and workforce pressures make any randomised controlled trial very difficult to execute. Willing participants are hard to find and staff turnover is high, making repeated measures or longitudinal designs problematic.

The lack of use of reliable or validated instruments (such as the Learning Transfer System Inventory (LTSI) (Holton, Bates & Ruona, 2000) is a weakness of the study. A pilot study did attempt to use the LTSI, but difficulties were encountered in collaborating with its authors to analyse the data. Qualitative descriptions of impact of training provided rich data which helped to interpret the quantitative findings, and findings from the secondary research. Issues of reliability were lessened by the triangulation of data from delegates and trainers on the evaluated courses. Due to the complexity of the issue of safeguarding adults, qualitative analysis and the factorial

survey combined were decided to be more effective measures of safeguarding adults training transfer than existing quantitative measures, which generally measure only one factor or dimension at a time, and do not provide as much meaningful data in a cross sectional context.

In this situation, the cross sectional study described is a good option. The systematic literature review updates understanding on the issue of training transfer generally, while the realist synthesis applies these findings to social care more specifically, and provides a programme theory, or mechanism of action by which safeguarding adults training is effective in specific circumstances. The factorial survey provides a quantitative measure of the effect of training and other variables on recognition and reporting of abuse. It also provides insight into the factors that may encourage or dissuade staff from making safeguarding adults alerts. The narrative analysis of qualitative interviews furthers understanding of the impact of the training, and also provides insight into the barriers and facilitators to safeguarding adults training transfer. A critique of each individual method and the limitations of the findings it provides is outlined below.

#### 12.4.2 Critique of individual methods

The systematic literature review, while including 90 papers, was limited by the fact that not all the databases searched by Burke and Hutchins (Burke & Hutchins, 2007) were accessible, despite extensive enquiries. This means that there may be other factors that influence transfer that were not identified in this review. In order to improve sensitivity and specificity, systematic reviews can be supplemented in three ways; by hand searching the journals most prevalent in the original search, doing the same with prevalent authors, or snowballing back or using a citation search to see

what preceded or succeeded papers found in the search. The systematic review undertaken here replicated the methods of Burke and Hutchins, but searched from 2005 to the present. It was decided not to supplement the general search due to resource constraints, but to focus instead on collecting evidence for the social care specific search as this was of most interest. However the transfer literature is well established and the findings from this review support previous reviews, and also included findings of a recent metaanalysis (Blume *et al.*, 2010). Therefore validity of findings does not appear to be compromised. The findings were obtained over a range of countries and settings, but synthesising the findings with those of the social care search and the empirical evidence has resulted in practical recommendations relevant to the UK safeguarding adults training context.

The factorial survey method has not previously been used, to the author's knowledge, to evaluate the impact of training. Logistically, it proved difficult to design and administer. Because of the nature of the computer programme recommended to administer the survey, it was only available on one laptop (rather than online as in other studies (Davies, 2011; Schwappach & Koeck, 2004)). This meant the researcher had to physically travel around Cornwall to see participants, which limited the scope for obtaining a very large sample. A sample size calculation was carried out, and the larger calculation adhered to using the assumption that sample size referred to number of vignettes, rather than number of people. If the study were repeated, the use of an alternative platform for the survey would be recommended, preferably online to facilitate greater ease of data collection and potential to survey a larger sample of people. However the size of the sample complied with statistical requirements so does not invalidate the findings.

Another limitation of the factorial survey was the collection of data about training that participants had attended. The question was phrased in numerous parts, which asked participants to indicate whether they had attended particular programmes. It was observed that numerous people were unable to recall whether, or when they had attended safeguarding adults training, and many of them thought they 'probably had' though they couldn't specifically remember it. Others had attended training by providers other than the Council, or previous versions of the Council's training, which may have been more or less effective. This means there is little certainty over which safeguarding adults programmes were evaluated here. It may be that the term "training" is ambiguous due to this, although the researcher made efforts to clarify which training was meant by taking along materials from the courses to show to participants. In future research, requests could be made for delegates to check their training records and bring along the specific details of courses they had attended when participating. This lack of certainty over which training was attended makes the findings regarding the lack of impact of training less credible, and may explain why findings relating to the impact of training on confidence and knowledge do not appear to match up between the factorial survey and qualitative data. It also raises questions over the purpose of attending if staff can't remember if they have or not.

Further limitations of using the factorial survey approach as a training evaluation method centre around the fact that it questions the hypothetical rather than the actual, so could only be classed as a measure of learning, rather than behaviour. It could be argued that knowing whether a vignette depicts an abusive situation does not require training; but managing it well in the workplace does. This may have led to the findings that training has no impact on recognition and reporting of abuse. Some of the



results indicated overcompensation in response to demand characteristics; for example, people were more likely to report a good friend than someone they had never been friendly with. The literature shows that whistleblowing will impact on interpersonal relationships if not handled well (Calcraft, 2007), and that strong staff cliques, friendships or loyalties can be a risk factor for abuse (Marsland, Oakes & White, 2007). Interview participants also acknowledged the challenge of alerting about colleagues. This finding provides some evidence against claims by authors such as Wallander, who state that factorial surveys result in participants being subjected to less social desirability bias (Wallander, 2009). It is possible that certain factors, such as reporting a friend, stand out more to participants who are keen to show compliance with policy. Furthermore, recognition and reporting of abuse were very highly correlated, whereas comparing abuse reporting figures (The NHS Information Centre Social Care Statistics, 2011a) to estimates of prevalence rates (O’Keeffe *et al.*, 2007) implies that abuse is still underreported. Some authors argue that removing the situation from its context may iron out other factors that impact on judgements (Lauder, Scott & Whyte, 2001), and this assertion is corroborated by the strongly positive correlation between recognition and reporting of abuse found here. These considerations should be taken into account when using factorial surveys for future research into safeguarding adults related issues, as the relationship between hypothetical and actual actions would need further investigation.

Another limitation of the factorial survey was that it appeared to be perceived as a mundane task for many participants. Because the overall structure of vignettes stayed constant with only details changing, numerous participants commented that the scenarios looked very similar. Although efforts were made to minimise rater fatigue by

asking each participant to complete only 8 vignettes (6 experimental and 2 baseline), it is possible that even this number was too many to maintain the attention of participants, meaning that important factors in the vignette may have been ignored. Again, using an online method of administration could result in asking each participant to complete fewer vignettes, while obtaining a larger sample, to minimise the risk of rater fatigue further. In terms of content of the vignettes, a decision had to be made to limit the number of factors for statistical reasons, so other major factors may have been missed. However it is unlikely that this would influence the validity of the findings; all but one participant (who had a meeting to attend) completed the whole programme of vignettes which implies that they managed to maintain a sufficient level of attention.

Concerning the qualitative analysis, the cross sectional design and lack of control group means that causal relationships between the training and alleged impacts of training cannot be inferred. However because the mechanism of action of training was explored, the findings relating the training to impact are more valid; delegates were able to explain which elements of the training led to transfer, which lends more weight to the notion that the impacts were in fact caused by the training. Furthermore the context, in terms of workplace supports, was also noted, meaning the findings acknowledge that a system of transfer supports additional to training is necessary to ensure transfer. This is in accordance with the transfer literature, lending further weight to the findings. However the impact of demand characteristics, which may have led to the exaggeration of impact, should also be considered. The triangulation of findings with the perspectives of trainers, in terms of impacts and facilitators and

barriers of transfer, goes some way to reducing any effects of demand characteristics meaning the validity of the findings is upheld.

#### 12.4.3 Sampling bias and generalisability

For the interview study, an attempt was made to avoid sampling bias by contacting a random sample of former delegates on the programmes. This method did not yield a sufficient number of respondents, so a sector wide email requesting participation was sent instead. The interview sample were difficult to recruit; many people who were approached did not have the time (or make it a priority) to participate. It is possible that only the staff who were interested in training, safeguarding or research volunteered to participate, meaning the bias was exaggerated towards people who were likely to be more positive about training. This was exemplified by the generally positive attitudes to preparation expressed by delegates in the interview study, which contrasted with trainers' perception that very few people completed it. One respondent was recruited after his manager failed to keep her interview appointment. He volunteered to participate instead, and his responses gave the impression of a more cynical attitude to training than other participants- he also stated that attending had had no impact on his practice. Generalisations cannot be made from this one person, but it is possible that he was more representative of non-respondents.

For the factorial survey, numerous methods of sampling were used in order to recruit a sufficient number of participants. Again, it is possible that only the staff who were interested in training, safeguarding or research volunteered to participate. Access to many staff groups was through gatekeepers (e.g. managers) which may have biased the sample further. There is no way of analysing the characteristics of non-respondents for either method, and it is difficult to meaningfully compare the

characteristics of respondents with those of the social care workforce in general due to patchy data (Skills for Care, 2011b). However it is safest to assume that the results present a more positive picture of the impacts of safeguarding adults training than truly exists in the sector. Because the study has resulted in a programme theory of safeguarding adults training, this potential overestimate of impact is less important, because it shows what can be achieved when the context facilitates the mechanisms identified.

Furthermore because the study is a case study of Cornwall, the generalisability of findings should be considered. An attempt has been made to describe Cornwall's health and social care context, which showed that Cornwall works under similar safeguarding adults policies and procedures to the rest of the UK (Stanley et al, 2011), although one interview respondent with a national post suggested the implementation and interpretation of the guidance varies widely across the country. Cornwall may also have a higher motivation to prioritise safeguarding because of recent inquiries into abuse. The study controls for context in terms of local authority processes and policy, because all providers in the county operate under the same guidance. However, the final programme theory does not contain any Cornwall specific features in terms of contexts and mechanisms; it describes a normative model of what the evidence suggests works best, in what context, for who and how. This can be applied anywhere, as it outlines the contextual features important to safeguarding adults training transfer. The outcomes, however, may be specific to Cornwall because they relate to two specific training programmes, the content and delivery of which are different in other areas of the country. Although the context and mechanisms necessarily relate to specific outcomes, the findings of the training transfer literature review and realist

synthesis suggest that the mechanisms established in the training transfer literature generally also operate in health and social care. Therefore while the specific outcomes will be dependent on the content of training programmes, the context and mechanisms necessary to produce training outcomes per se are similar. This hypothesis could be tested in further, comparative research.

#### 12.4.4 Researcher bias

The researcher helped to design the two safeguarding adults training programmes that this study focusses on. Bias that the researcher had towards reporting a favourable outcome was reduced by the fact that the evaluation of the training was not the main objective; rather, the programme theory was evaluated using data from the training evaluation. Residual bias was controlled by using pre-defined p and R values in the quantitative aspects of the research, but in the qualitative aspects it is possible that the participants were responding to demand characteristics when answering positively. The researcher endeavoured to report the qualitative results in an unbiased manner, while acknowledging the difficulty of both coding and reporting in an objective way. As mentioned above, by interviewing trainers as well, a more objective overview of reactions to, engagement with and impact of the training was sought; however the researcher was known to all 3 trainers, as she had worked with them on other projects in the past. A disadvantage of this was that they were aware of her interest in training transfer, but an advantage was that they were candid about their experiences. Findings corresponded to the transfer literature in terms of identification of factors in the workplace and in training that help and hinder transfer, so it is unlikely that validity of findings was adversely impacted. Furthermore, the differences in responses to particular issues (e.g. preparation work) between trainers and

participants imply that sampling bias may have been more of an issue than researcher bias.

## 12.5 Future research

A number of potential new avenues for research were highlighted during the literature review, including some factors that have until now received little attention in the literature. The impact of attitudes to training in itself was not covered in depth in this review, but previous research has established that attitude towards training impacts on transfer. Noe (1986) outlined the concept of trainability, which comprises ability, motivation and perceptions of the work environment, and elaborated on it with a model of motivational influences on training effectiveness, many components of which have been verified as important transfer antecedents in more recent research. However attitudes to the content of training have not been explored in as much depth, and this could be a useful avenue to explore in health and social care training research, where learning and development is as much about values and attitudes towards particular groups of people or topics as demonstrable skills. Some studies have demonstrated the merit of using interventions to reduce negative attitudes towards older people (Gonzales, Morrow-Howell & Gilbert, 2010; Westmoreland *et al.*, 2009) and further research could investigate whether conducting a pre-training intervention such as this could help to maximise transfer for a programme such as safeguarding adults. Other studies have discussed the importance of framing value-based training messages in a way acceptable to practitioners (Antle *et al.*, 2010), and again this would be a useful subject to apply to safeguarding adults training research. This would also be useful research to carry out in the context of the perceived conflict between mandatory training and the principles of adult learning (Mythen & Gidman, 2011), with

the aim of finding a way to increase pre-training motivation to attend for mandatory courses.

Trainer characteristics were a factor identified in the intervention design and delivery section that have not received much attention to date. Health and social care based studies mentioned the importance of trainer credibility (Gauntlett, 2005), trainers' acknowledgement of the good work already being carried out (Collins, 2008) and trainers' acknowledgement of the challenges of applying the learning to practice (Antle *et al.*, 2010). It is possible that attributes such as these are more important in health and social care, due to challenging working conditions. The importance of trainer credibility was highlighted by interviewees in this study, both by trainers who recognised the importance of sharing their own professional experience as practitioners and recognising the reality of practice, and by delegates from both courses who appreciated the trainers' competence. Safeguarding adults is a grey area, meaning the importance of having a trainer who can pass on their confidence in their ability and actions is heightened. Further research on the qualities necessary for health and social care trainers to be effective may be of use.

Interactive training involving case studies and group discussion enhanced the relevance of the courses. There is, however, a question of what the best mix of delegates is; while managers were, on the whole, appreciative of the opportunity to meet managers from other services and agencies, some Human Rights delegates thought the wide mix of attendees made the course less relevant for them. The effectiveness of interagency training is a contentious issue (Barr *et al.*, 1999; Hammick *et al.*, 2007; Reeves *et al.*, 2010), and has not been investigated in a safeguarding adults training context to date. The mechanism of action for multiagency training

appears to be based on an assumption that training people together changes attitudes towards and increases understanding of other professions, and this facilitates multiagency working- but there is little evidence of training specifically leading to multiagency working. Comparative research investigating if and how multiagency safeguarding adults training works would be valuable.

Confidence is an important antecedent of changed practice in safeguarding adults, but the relationship between training and confidence is complex. Findings from this study imply that training on its own may decrease confidence; when training is combined with opportunity to use, confidence is increased and transfer is more likely. These hypotheses could be explored further to find out what makes a confident safeguarding adults practitioner.

The general lack of evidence of impact of training on people who use services could be remedied by surveying people who have had an alert made about them about their experience of the process, or surveying people about how 'safeguarded' from abuse they feel. Although the ethics of such research would need careful consideration, the impact of training on the people whose lives it is meant to affect is important to measure. Adjusting the content of training programmes to focus as much on empowerment and self-advocacy as process could help in designing measurable objectives in this respect.

Comparative studies comparing the mechanism of action of safeguarding adults training of different English counties or areas could test the and refine the programme theory resulting from this research, to check its generalisability, and determine what, if any, other contextual features or mechanisms are at work in safeguarding adults



training transfer elsewhere. Intervention studies are needed to investigate how those mechanisms and contexts can be promoted and embedded in the sector.

Finally, this research did not address the issue of cost effectiveness and return on investment of safeguarding adults training. Future research could assess how variations in different aspects of training investment- such as length of time of course, preparation time, and follow up time affect the impacts of training programmes.

## **12.6 Conclusions**

The evaluation of the safeguarding adults programmes provided in Cornwall showed some evidence of an impact on practice. Managers were able to affect greater change than non-managers, and this may have been due to a combination of the structure of their course which included an action plan and follow up support, and the autonomy they experienced as managers. Confidence increases were one of the main impacts from the course, highlighting the need for follow up support to improve practitioners' confidence in their safeguarding adults performance.

Due to the lack of evidence on impacts for people who use services, it is recommended that training provides more of a focus on promoting structures such as self- advocacy, advocacy and whistleblowing support, within a climate that views safeguarding as a positive process, to enhance the possibility of abuse identification and disclosure. The human rights focussed approach used in Cornwall is a useful step in making the transition from a 'safeguarding from harm' to a 'promotion of rights' model.

The need to consider the transfer climate has also been highlighted. While this is important in the context of safeguarding adults training, it also applies to training generally in social care sector. A range of literature found in the social care search,

concerning a number of different programmes, highlighted issues related to the transfer climate and addressing these should be a priority for the sector. This is particularly important if training is to be used as one of the main tools to develop the workforce.

Aylett (2008) points out that there are no new lessons in safeguarding adults, just the need to learn and implement the old ones. Training is regarded as one of the main mechanisms to achieve this. One possible explanation for the repetitive nature of serious case review recommendations following incidents of adult abuse is that training has been ineffective, and the findings of this study suggest that this may be due to a lack of adherence to the principles of training transfer in the sector as a whole. This also represents a case of 'no new lessons'; the transfer literature is mature and well established. By implementing the recommendations based on the findings of this research, safeguarding adults practice should be improved in the sector. As well as representing better use of resources spent on training, this has the potential to have a positive impact on the lives of a great number of people at risk of abuse.

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## **Appendix A      Abbreviations**

<b>ACS</b>	Adult Care and Support
<b>ADSS</b>	Association of Directors of Social Services
<b>BBC</b>	British Broadcasting Cooperation
<b>CMO</b>	Context- Mechanism- Outcome
<b>CSCI</b>	Commission for Social Care Inspection
<b>CQC</b>	Care Quality Commission
<b>CRB</b>	Criminal Records Bureau
<b>DOLS</b>	Deprivation of Liberty Safeguards
<b>EPPS</b>	Electronic Performance Support Systems
<b>ERIC</b>	Educational Resource Information Centre
<b>GSCC</b>	General Social Care Council
<b>HR</b>	Human Resources
<b>HuR</b>	Human Rights
<b>IT</b>	Information Technology
<b>KTP</b>	Knowledge Transfer Partnership
<b>LSIS</b>	Learning and Skills Improvement Service
<b>LTDU</b>	Learning Training and Development Unit
<b>LTSI</b>	Learning Transfer System Inventory
<b>NHS</b>	National Health Service
<b>NICE</b>	National Institute for Clinical Excellence
<b>NMC</b>	Nursing and Midwifery Council
<b>OLS</b>	Ordinary Least Squares
<b>PCAW</b>	Public Concern at Work
<b>POVA</b>	Protection of Vulnerable Adults
<b>PM</b>	Provider Manager

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<b>PRISMA</b>	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
<b>PRTL</b>	Post Registration Training and Learning
<b>RAMESES</b>	Realist and Meta-review Evidence Synthesis: Evolving Standards
<b>RCT</b>	Randomised Controlled Trial
<b>REC</b>	Research Ethics Committee
<b>Ripfa</b>	Research in Practice for Adults
<b>RQ</b>	Research Question
<b>SCIE</b>	Social Care Institute for Excellence
<b>SE</b>	Standard Error
<b>SLR</b>	Systematic literature review
<b>SPSS</b>	Statistical Package for the Social Sciences
<b>SS</b>	Same Source
<b>SSC</b>	Same Measurement Context
<b>UK</b>	United Kingdom
<b>USA</b>	United States of America

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## Appendix B Data comparing Cornish and English social care workforce data.

Cornwall's data is from June 2011, and incorporates data from just under 6,500 staff. England data is also from June 2011, from 25,181 services, representing over 600,000 staff. Data is based on the National Minimum Data Set for social care, administered by Skills for Care (Skills for Care 2011). The data is not complete so should be viewed only as a guide.

	Cornwall	England
<b>Gender</b>		
Female	77%	78%
Male	20%	16%
<b>Age</b>		
18-24	16%	11%
25-34	20%	19%
35-44	19%	47% (merged categories)
45-54	24%	
55-64	17%	19% (merged categories)
Over 65	4%	
<b>Ethnicity</b>		
White	66%	62%
Not recorded	30%	19%
<b>Nationality</b>		
British	93%	85.4%
Top 5 other nationalities:	Polish, Hungarian, Romanian, Indian, Other	Phillipino, Nigerian, Zimbabwean Indian, Polish,

Disability		
No disability	82%	79%
Disability	1%	2%
Not recorded	17%	19%
Year started current job		
2011- (<1 year)	6%	(7.6%)*
2009-2010 (<3 years)	37%	(34.4%)*
2005-2008 (<6 years)	37%	(31.6%)*
2000-2004 (<12 years)	12%	<7 years: 22.1%*
Pre 2000 (>12 years)	6%	
Year started work in social care		
2011- <1	3%	(1.4%)*
2009-2010 (<3 years)	21%	
2005-2008 (<6 years)	26%	
2000-2004 (<12 years)	13%	<10 years ago: 25.7%*
Pre 2000 (>12 years)	16%	>10 years ago: 14.4%*
Salaries (median)		
Registered manager	19,729	28,000
Senior Care Worker	14,014	16,212
Care Worker	13,477	12,948
Working arrangements		
Full time	48%	Not available
Part time	38%	Not available
Permanent staff	95.2%	96.3%
Temporary staff	4.8%	3.7%



Vacancy rate	2.4%	2.9%
Turnover rate	20.9%	18.6%
Sick leave		
0 days	51%	58.9%*
1-6 days	15%	24.7%*
Not recorded	24%	Not available*
Qualifications		
No qualifications	30%	Not recorded
Level 1	0%	Not recorded
Level 2	20%	All level 2 and above: 32% achieved.
Level 3	15%	
Level 4+	4%	
Other social care	8%	

\* England data in this category was not listed in the June 2011 report, so is taken from the 2010 annual report (Eborall 2010).

## Appendix C Rationale for classifying safeguarding adults training as a complex social intervention

Complex social interventions have seven key characteristics, outlined in the table below. Pawson et al (2004) use the example of league tables to illustrate each characteristic, given in the first column. The rationale for classifying safeguarding adults training as a complex social intervention is also given.

Characteristics of complex social interventions	Rationale for Safeguarding Adults training as a complex social intervention
<ul style="list-style-type: none"> <li>The intervention is a <b>theory or theories</b> – when performance league tables are published there is an implicit (and rarely stated) rationale about how they will affect people and organisations (and hence how they will bring about change).</li> </ul>	<p>Safeguarding adults training assumes that providing the workforce with input about how vulnerable adults should be safeguarded from abuse will result in improved performance in safeguarding. The implicit rationale is that training leads to learning which leads to changed performance.</p>
<ul style="list-style-type: none"> <li>The intervention involves the <b>actions of people</b> – so understanding human intentions and motivations, what stakeholders know and how they reason, is essential to understanding the intervention.</li> </ul>	<p>Any training relies on trainers to successfully communicate a message, and delegates to implement their learning in practice. Therefore an understanding of how to encourage this is required to make the training successful.</p>
<ul style="list-style-type: none"> <li>The intervention consists of a <b>chain of steps or processes</b> – in our example, the development of indicators, their publication and dissemination, the creation of sanctions or incentives, and the response of those being measured. At each stage, the intervention could work as expected or ‘misfire’ and behave differently.</li> </ul>	<p>Safeguarding adults training is mandated, then regional teams devise a training programme and competencies. Training is delivered to delegates, and delegates are then expected to implement their learning back in their workplace.</p>
<ul style="list-style-type: none"> <li>These <b>chains of steps or processes are often not linear</b>, and involve negotiation and feedback at each stage. For example, healthcare organisations and professionals may have to provide the data for performance measurement, and securing their cooperation may involve a number of trade-offs and distorting influences.</li> </ul>	<p>Evaluation of training, changes in process (regional or national), groups to which the training is delivered, and information on maximising training effectiveness can all affect the training intervention.</p>

- Interventions are **embedded in social systems** and how they work is shaped by this context. For example, publishing performance data for cardiac surgeons and for psychiatrists may produce very different behaviours because of the different nature and context of those services and specialties.

The delivery of the training is affected by its reception by the delegates; much evidence supports the theory that training transfer is dependent on factors in the workplace. A systems approach is appropriate when considering training transfer.

- Interventions are **prone to modification** as they are implemented. To attempt to 'freeze' the intervention and keep it constant would miss the point, that this process of adaptation and local embedding is an inherent and necessary characteristic. It means that different applications of the 'same' intervention (such as publishing performance league tables), will often be different in material ways.

Safeguarding adults training is a prime example of this; local authorities all have an individual approach to rolling out such training, and courses are frequently adapted and changed.

- Interventions are **open systems and change through learning** as stakeholders come to understand them. For example, once performance measures are put in place and published, those being measured soon learn to 'game' or optimise the way they score, and the developers of the measures have to respond by changing the system to prevent such gaming distorting the process and intended effects of measurement.

Feedback and evaluation of training changes content and delivery; as targeted groups become familiar with systems (e.g. booking procedures, prerequisites) these can be developed.

## **Appendix D      Search strategy- systematic literature review.**

1. Transfer of learning
2. Learning AND transfer
3. Training AND transfer
4. Skill\* maintenance
5. Skill\* generalis\*

## Appendix E Systematic literature review screening sheet

Author	
Reference	
Peer reviewed paper? (discount if not)	
Meta analyses?	
Empirical findings (direct observation/ experiment- is there data in the paper!?)	
Qualitative work with theoretical lens?	
(discount if none of the above)	
Other (state)	
Does the paper address: <ul style="list-style-type: none"> <li>• Learner characteristics</li> <li>• Intervention design and delivery</li> <li>• Work environment influences</li> </ul> (discount if none of the above)	
Transfer construct defined explicitly?	
OR other indication that transfer is criterion of interest?	
Include in review?	
Useful for other purposes? <ul style="list-style-type: none"> <li>• Background</li> <li>• Social care search?</li> <li>• Methods (specify)</li> <li>• Vignettes</li> <li>• Survey</li> <li>• Other</li> </ul>	

## **Appendix F      List of journals that Zetoc alerts were received for**

AGING AND MENTAL HEALTH

BRITISH JOURNAL OF DEVELOPMENTAL DISABILITIES

BRITISH JOURNAL OF SOCIAL WORK

BULLETIN- ANN CRAFT TRUST

CLINICAL SOCIAL WORK JOURNAL

CLINICAL SUPERVISOR

EDUCATION AND TRAINING -LONDON THEN BRADFORD-

EDUCATION AND TRAINING IN DEVELOPMENTAL DISABILITIES

EVALUATION AND THE HEALTH PROFESSIONS

HEALTH & SOCIAL WORK

HUMAN RESOURCE DEVELOPMENT INTERNATIONAL

HUMAN RESOURCE DEVELOPMENT QUARTERLY

HUMAN RESOURCE DEVELOPMENT REVIEW

INTERNATIONAL JOURNAL OF TRAINING AND DEVELOPMENT

INTERNATIONAL JOURNAL OF TRAINING RESEARCH

INTERNATIONAL SOCIAL WORK

JOURNAL OF ELDER ABUSE AND NEGLECT

JOURNAL OF EUROPEAN INDUSTRIAL TRAINING

JOURNAL OF EVIDENCE BASED SOCIAL WORK

JOURNAL OF MENTAL HEALTH TRAINING EDUCATION AND PRACTICE

JOURNAL OF SOCIAL WORK

JOURNAL OF SOCIAL WORK EDUCATION

JOURNAL OF SOCIAL WORK PRACTICE

PERFORMANCE IMPROVEMENT

PERFORMANCE IMPROVEMENT QUARTERLY

RESEARCH HIGHLIGHTS IN SOCIAL WORK

RESEARCH ON SOCIAL WORK PRACTICE

SAFETY EDUCATION -LONDON- ROYAL SOCIETY FOR THE PREVENTION OF ACCIDENTS-

SOCIAL POLICY AND ADMINISTRATION

TRAINING -NEW YORK THEN MINNEAPOLIS THEN NEW YORK-

**Appendix G      Systematic literature review: Data extraction  
form fields**

	<b>Health and social care based?</b>
	<b>Author</b>
	<b>Year</b>
	<b>Ref</b>
	<b>Country</b>
	<b>Type</b>
<b>Findings: Individual factors (tick all that apply)</b>	Cog ability
	Self eff
	Motivation
	Personality
	Perceived utility/ value
	Locus of control
	Other (state)
<b>Findings: Intervention design (tick all that apply)</b>	Needs analysis
	Learning goals
	Content relevance
	Instructional strategies
	Self-management strategies
	Technological support
	Other (state)
<b>Findings: Work environment factors (Tick all that apply)</b>	Strategic link
	Transfer climate
	Supervisor/ peer support
	Opportunity to perform
	Accountability
	Other (state)
<b>Other?</b>	Anything else
<b>Question</b>	Did the paper address a clear research question, and if so
	What programme theory is it testing?



	Terms defined clearly?
<b>Design</b>	What was the study design; was it appropriate to the
<b>Context</b>	What was the context of the study? Was this sufficiently well described that the findings can be related to other settings?
<b>What type of training was</b>	Is there enough information about programme?
<b>Evaluation</b>	At what level, and using what methods was the intervention evaluated? (highest if >1)
	Further details
<b>Measures used</b>	1. What measures of effectiveness were included in the
<b>Sampling</b>	1. Did the researchers include sufficient cases/settings/ observations? [could conceptual rather than statistical
<b>Data collection</b>	Was the data collection process systematic, thorough and
<b>Data analysis</b>	Were the data analysed systematically and rigorously? How were disconfirming observations dealt with?
	Have sufficient data been presented to allow the reader to assess independently whether analytical criteria have been
	How were disconfirming observations dealt with?
<b>Results</b>	What are the main results and in what way are they surprising, interesting, or suspect? [Include any intended
<b>Flaws</b>	What problems or weaknesses are there with the study?
<b>Conclusions/ implications for practice</b>	Did the authors draw a clear link between data and explanation (theory)? If not, what are your reservations?
<b>Ethical</b>	
<b>Refs to follow up?</b>	

## Appendix H Search 2, realist synthesis: Data extraction form fields

Author	
Year	
Title	
Country	
Study type	
Study objective	
Terms defined clearly?	
What was the study design; was it appropriate to the question? Measures?	
Time of evaluation (pre-post training); baseline?	
Control?	
Who attended the training?	
What were the outcomes of the intervention?	
Information about intervention characteristics?	
Intervention objective	
Mechanism- reporting underlying assumption about how intervention was meant to work, and description of mechanisms researched/ mentioned in discussion	
1.8.1 Problem identified: adult abuse is occurring on a large scale. Safeguarding adults training is mandated in policy Assumption 1: Knowledge gap for staff is a causal/ contributing factor to its persistence. Ass2: mandating training will ensure compliance.	
1.8.2 Regional training teams devise training programme Ass1: Principles of adult learning are adhered to Ass 2: Principles of training transfer are adhered to Ass 3 workforce understand that training is for the purpose of addressing a knowledge gap, and that practice change	

should result	
1.8.3 Trainers deliver programmes to health and social care staff Ass1: the right people attend	
1.8.4 Delegates transfer learning to practice Ass 2: training transfer and (safeguarding adults) support mechanisms are in place	
What was the context of the study? Was this sufficiently well described that the findings can be related to other settings?	
Level of evaluation	
Alternative explanation for results	
Comments	
References to look up	

## Appendix I Studies using the factorial survey method

Study	Topic	Sample	Completed vignettes, dimensions and levels	Dependent Variable	Method	Analysis
Applegate, Cullen, Link, Richards, Lanza-Kaduce, 1996	Determinants of public punitiveness toward drunk driving	Community residents- Cincinnati. 400 sampled, 205 usable questionnaires returned. (52.4%),	65,856 possible vignettes. 205 vignettes obtained (one each).	Harshness of sanction; 1 (the driver should not be punished at all) to 13 (life in prison).	Postal survey, numerous follow ups. Only ONE vignette requested from each respondent.	Descriptives re harshness of sentence; t-test to compare levels of harm led to categorising fatal vs. non-fatal. Regression model used. Logistic regression chosen over linear (because DV is ordinal) (pg. 72)
Davies, (2011) (thesis)	Factors used in the detection of elder financial abuse	UK social care, health and banking professionals (70 SC & B, 82 health)	20,736 possible vignettes. 65 case scenarios produced for social care and health staff; 46 for banking staff.	Certainty that abuse is occurring (1-100) and action (1- unlikely to take action to 100, likely to take action).	Used fractional factorial design; so all participants judge the same sample set.	Multiple regression. Used unstandardised beta coefficients as included dummy variables.
Garret (1982)	Seriousness of various types of	301 respondents (adults living in	17,345 rated vignettes.	Rating of seriousness of	Each participant responded to 64	Vignette used as unit of analysis.

Study	Topic	Sample	Completed vignettes, dimensions and levels	Dependent Variable	Method	Analysis
	child abuse; looking at the act, characteristics of those involved, and characteristics of raters.	the LA area)		abuse 1(not serious) to 9 (very serious).	vignettes. Vignettes were printed on paper and included 4 "give-away" vignettes to guard against bias created by the first vignette presented to respondents.	
Hennessy (1993)	Informational factors and judgement processes involved in making case management decisions in long term care.	38 professional members from multidisciplinary team	1,507 vignettes obtained. 24 dimensions, 79 levels; 1,099,496,032,600 potential vignettes.	Risk of institutionalisation: scale of 1 (an individual who meets the minimum eligibility criteria" to 100 "requiring placement in a nursing home".  Care plan choice: categorical ordering of care plan choices (5	Each participant responded to 40 vignettes.	Vignette is unit of analysis. 1-100 scale treated as interval data. Client, org and rater characteristics dummy variables  Error components regression used as OLS regression assumptions violated (responses non independent).  Categorical data (care plan choices) analysed using ordered probit.

Study	Topic	Sample	Completed vignettes, dimensions and levels	Dependent Variable	Method	Analysis
				options).		
Hennessy (1995)	Identifying HIV vaccine trial design features that would encourage voluntary participation.	Gay and bisexual men. Vignettes administered in groups of 8-15. No further info.	12 dimensions, 31 levels. = 23328 potential vignettes.	What is your likelihood of participation in this vaccine trial? 0-100, anchored at certainly no, undecided, certainly yes.	Each participant responded to 10 different vignettes.	Random effects regression analysis.
Killick and Taylor, 2011	Judgements of elder abuse	190 completed questionnaires. 2261 vignettes as unit of analysis- some people did not complete all.	23 factors identified in systematic lit review.	To what extent do you perceive this to be abuse? 0 not abuse- 9 abuse. How likely would you be to refer this case for investigation? Not likely 0- very likely 9	Each p responded to 16 vignettes.	Multiple regression
Lauder et al (2001)	Nurses' judgements of self-neglect and lifestyle choice;	Sampled 3 groups of nurses (100 psychiatric	1894 usable vignettes for analysis.	Judgement of self-neglect and choice, on 7 point visual analogue	Postal survey of 10 randomised vignettes, cover letter and return	Descriptive; inferential parametric and non-parametric (ANOVA, Kruskal Wallis, Spearman's

Study	Topic	Sample	Completed vignettes, dimensions and levels	Dependent Variable	Method	Analysis
	construction and influencing factors.	100 general nurses (65 students). Total 190 participants (67, 59, 64)	6 dimensions, 17 levels, total of 432 unique vignettes.	scale. Anchored by “not self-neglecting” (1) and “severely self-neglecting” (7) for neglect, and “has chosen to lead lifestyle” (1) and “has chosen no aspect of lifestyle” (7), for lifestyle choice.	addressed envelope.	correlation); categorical regression (“a form of multiple regression technique suitable for ordinal and categorical variables” pg. 604)
Ludwick, O’Toole, O’Toole and Webster, 1999	Nurses judgements on whether a patient is confused and should be restrained.	Sampled 138 registered nurses, 100 respondents (73.5%)	2073 vignettes used.	Recognition of confusion (0-9, not confused- extremely confused) and intervention for confusion (0-9, unlikely to restrain- likely to restrain with a posey vest and	Each respondent judged 30 vignettes. Plus three “giveaway vignettes” (baseline vignettes) Postal survey.	Ordinary least squares with dummy coding. Baseline average scores used to control for individual differences in subject responses.

Study	Topic	Sample	Completed vignettes, dimensions and levels	Dependent Variable	Method	Analysis
				restraints to all four extremities)		
Muller-Engelmann, Krones et al (2008)	Types of clinical situations in which a shared decision making style is preferred by patients and physicians.	(proposed) 300; 100 each of GPs, patients and members of self-help groups. Propose using conservative ANOVA for fixed effects, special, main effects and interactions. Explained rationale.	(proposed) 7 dimensions x 17 levels. 432 potential vignettes. Non completed as survey not actually carried out.	5 point scale for response to each vignette given (categorical- 5 diff options of response).	11 vignettes each. 40 sets of vignettes will be randomly drawn with replacement from the pool of vignettes. Distribution will be at random between groups.	Vignette as unit of analysis. Propose using mixed models. Factors coded as dummy variables. Hierarchical models seen as more appropriate as judgements are not independent so Ordinary Least Squares can't be used.
O'Toole, Webster et al (1999)	Effect of characteristics of case, teacher, and organisational setting on recognition and	716 teachers identified using a list supplied by a public body. Probability sample (N= 480)	11,443 recognition and 11,328 reporting vignettes collected. 9 dimensions and 35 levels,	Recognition and reporting of child abuse, measured on a 10 point continuum, from "not child abuse" to "child abuse"	Teachers were paid \$35 for the interview, conducted at their convenience. Total of 28 vignettes each (4 base	Vignettes used as unit of analysis. Ordinary least squares regression used as assumptions underlying the factorial survey were met. Respondents tended to use the upper end of the



Study	Topic	Sample	Completed vignettes, dimensions and levels	Dependent Variable	Method	Analysis
	reporting of child abuse.		resulting in 8448 potential vignettes.	and “unlikely to report” to “likely to report”.	vignettes).	continuum; this was controlled for with base vignettes. Average score on base vignettes used as a covariate in regression models.
O’Toole, O’Toole, Webster and Lucal, 1993	Nurses recognition and reporting of child abuse	Probability sample. 1555 sampled, 1038 returned (68%)	7 dimensions, 20 levels, 1152 potential vignettes. Obtained 22,422 recognition and 24,372 reporting.	Recognition (0-9, not child abuse-child abuse) and reporting (0-9, unlikely to report-likely to report).	4 base vignettes. 24 random vignettes included for each nurse. Postal survey with two follow up reminders.	Ordinary least squares. Participants used upper end of scale: controlled for with baseline vignette average scores. Case characteristics accounted for 47% of the variance. <0.5% explained by nurse characteristics. 0.1% explained by organisational characteristics. Base vignettes 3 <sup>rd</sup> most important predictor of recognition and reporting.
Schwappach and Koeck (2004)	Effect of characteristics of medical errors,	Members of public via internet survey;	2889 judgements analysed.	7 point severity rating scale (minor error- very	3 vignettes each.	Unit of analysis was response to each vignette, not respondent. Four

Study	Topic	Sample	Completed vignettes, dimensions and levels	Dependent Variable	Method	Analysis
	and physicians' subsequent handling of errors on patients' evaluation of incident.	1200 invited to participate. 1017 participated; 984 completed.	6 dimensions, 17 levels. Total of 486 potential vignettes. This was reduced to 27 using "fractional factorial design".	severe error). Points 1-4 small numbers, so combined into one category for analysis. Seek referral to other physician? Report error? Consequences for physician?		separate logistic and ordered logistic regression models were estimated, in which vignette attributes and participant characteristics explained the binary or ordinal responses. Results presented as odds ratios- "the odds of observing a response in a higher outcome category versus the lower category for a unit change in the dependent variable".

## Appendix J      Example of vignettes with low and high difficulty ratings.

Examples of vignettes with the lowest, and highest possible difficulty rating are shown below:

You enjoy your work, as you have a supportive manager and colleagues. In the past, you have seen things that could have been done better. Your organisation has listened to your concerns and acted on them. Currently you are working with a person who is older and lives in residential care. You have worked with this person for some time, and find them generally cooperative and appreciative of services. You have noticed that your colleague frequently shouts insults at the person. You think your colleague has behaved in this way with other people before. The person has told you that your colleague hurt them. You and the person have agreed that you can share information about them when necessary. You and your colleague have never been very friendly.

Lowest possible difficulty rating (above)

You enjoy your work, despite your unsupportive manager and colleagues. In the past, you have seen things that could have been done better. Your organisation has dismissed your concerns and branded you a troublemaker. Currently you are working with a person who is older and lives in residential care. You have worked with this person for some time, and find them difficult to engage with, as they often make up stories. You have noticed that the person has given your colleague the PIN number for their bank card. Your colleague regularly withdraws money for them. You believe the person has the mental capacity to make this decision. This is the first time you've been aware of your colleague behaving in this way. The person has told you that they get on really well with your colleague. The person has also asked you not to tell anyone about the situation. You are good friends with your colleague and believe they wouldn't have meant any harm.

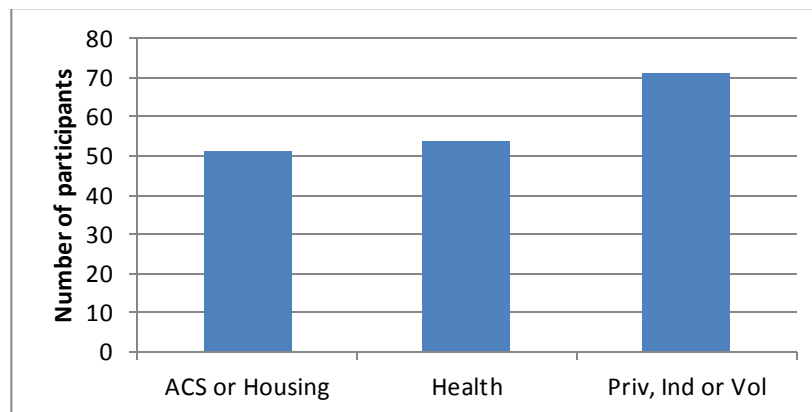
Highest possible difficulty rating (above)

## Appendix K Factorial survey participant demographic data

### K.1. Organisation

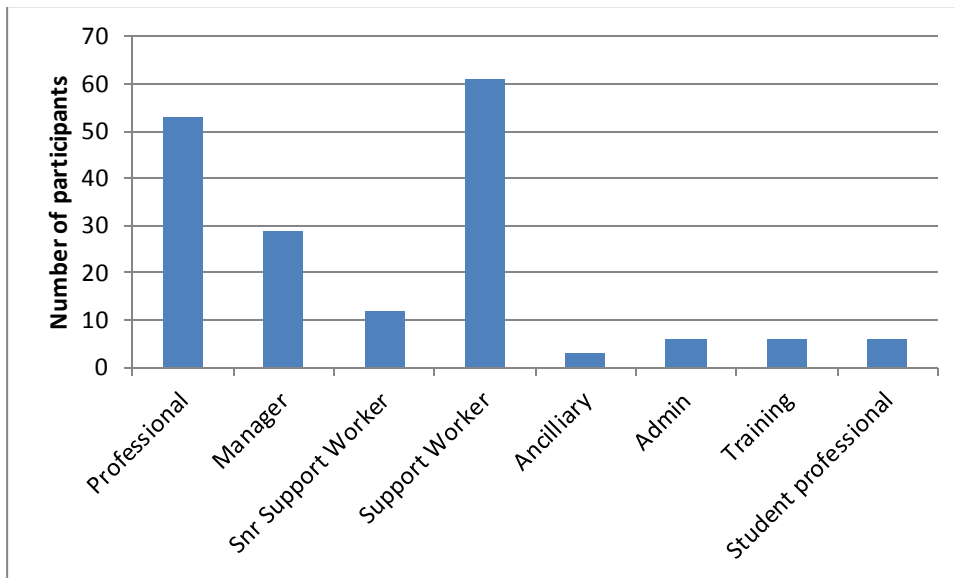
Organisation	% of sample (n)
Adult Care and Support/ Housing	29% (n=51)
Health	31% (n= 54)
Private, Independent or Voluntary Sector	40% (n=71)

99% were paid staff, as opposed to 1% volunteers.



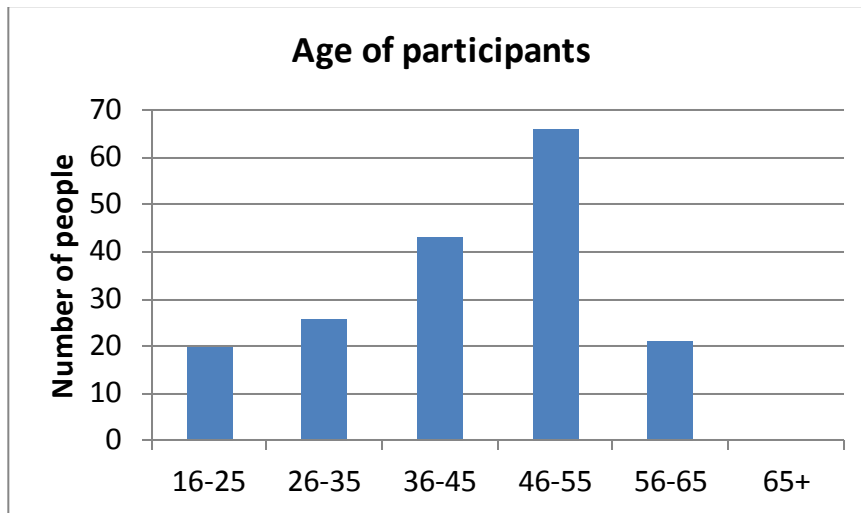
### K.2. Job type

Type of job	% of sample (n)
Professional, student professional or manager	50% (n=88)
Senior support worker/ support worker	41% (n= 73)
Ancillary and Administrative	5% (n= 9)
Training	3% (n= 6)



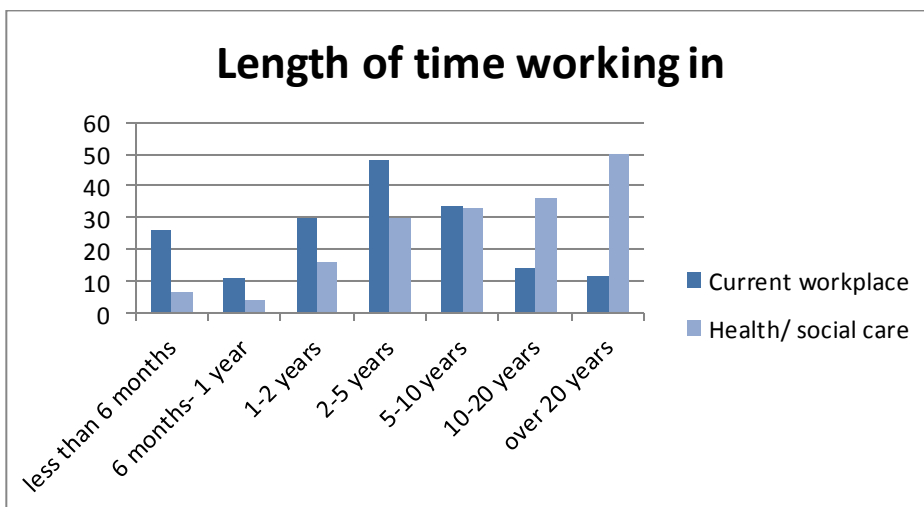
*K.3. Age*

Age	% of sample (n)
16-25	11% (n=20)
26-35	15% (n=26)
36-45	24% (n= 43)
46-55	38% (n=66)
56=65	12% (n=21)
65+	0% (n=0)



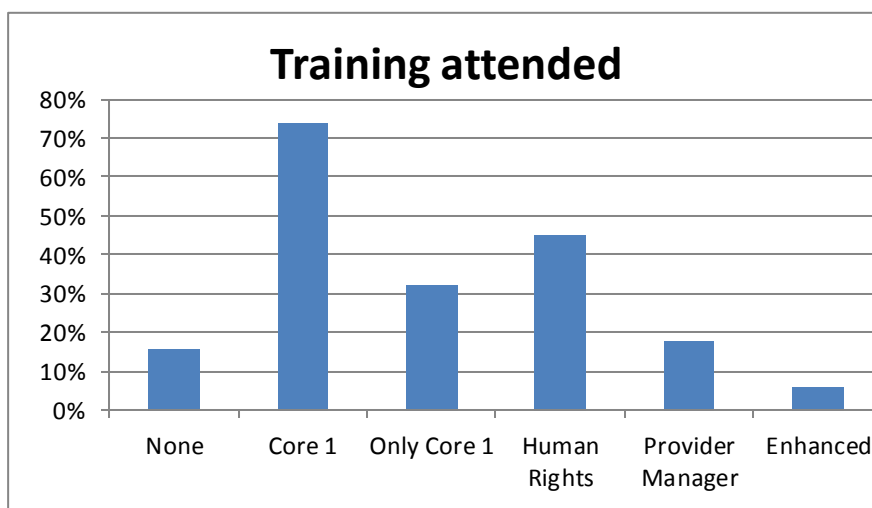
*K.4. Worked in the sector / Worked in current workplace*

	Current workplace	Health/ social care
<b>less than 6 months</b>	26	7
<b>6 months- 1 year</b>	11	4
<b>1-2 years</b>	30	16
<b>2-5 years</b>	48	30
<b>5-10 years</b>	34	33
<b>10-20 years</b>	14	36
<b>over 20 years</b>	12	50



*K.5. Training attended*

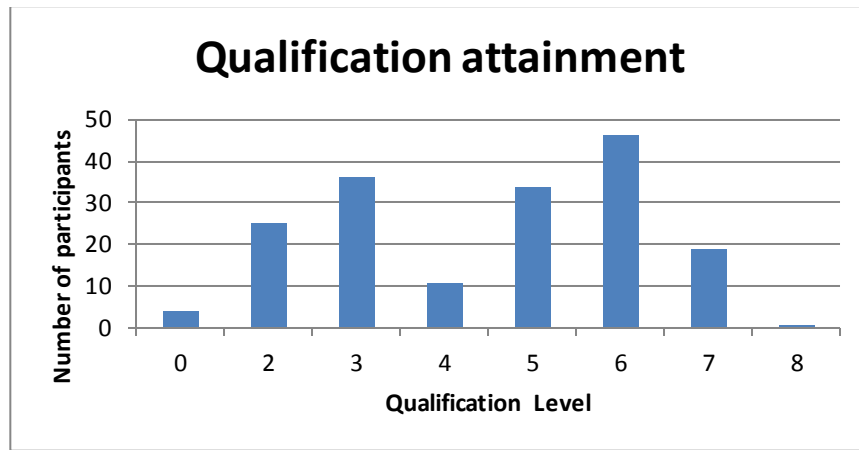
<b>None</b>	<b>16%</b>
<b>Core 1</b>	<b>74%</b>
<b>Only Core 1</b>	<b>32%</b>
<b>Human Rights</b>	<b>45%</b>
<b>Provider Manager</b>	<b>18%</b>
<b>Enhanced</b>	<b>6%</b>



Note: percentages do not add up to 100 because numerous people attended more than one programme. The training measure was taken to be the highest level of training that had been attended.

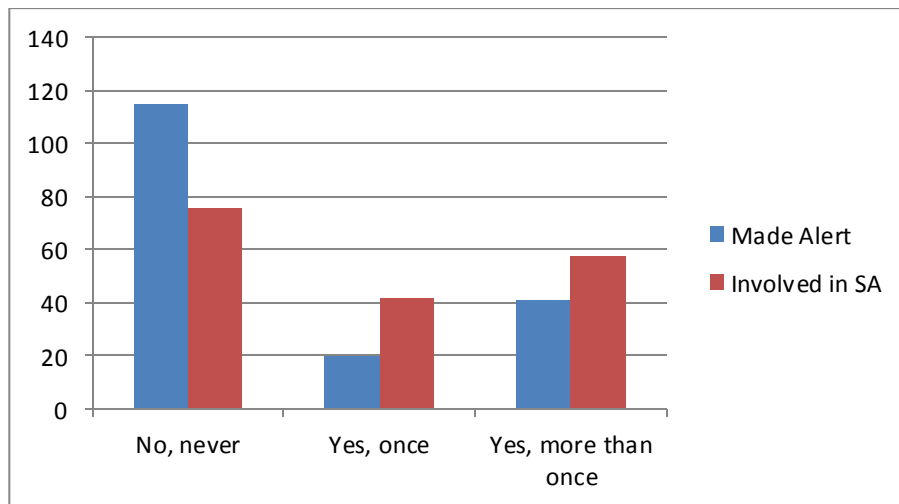
*K.6. Qualification attainment*

Qualification level	Number of participants
0	4
2	16
3	29
4	11
5	3
6	44
7	17
8	1



*K.7. Safeguarding experience*

	Made Alert	Involved in SA
<b>No, never</b>	115	76
<b>Yes, once</b>	20	42
<b>Yes, more than once</b>	41	58





## **Appendix L      Interview script: Provider Manager/ Team Leader workshop**

<b>Interview Script- Provider Manager/ Team Leader Workshop</b>
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### **Preamble**

The purpose of this interview is to gain a more in depth understanding of:

- The impact that the Provider Manager/ Team Leader workshop has had on your practice
- Your experiences of the workshop in terms of transferring learning to your workplace (e.g. how the workshop has affected what you do at work)
- Whether anything in the workshop, or in your workplace helped or hindered you in using the new learning in your work.

I have several main questions which you have already received, and I expect it will take us between half an hour and an hour to complete them.

The information you provide me with today will remain completely confidential to the extent that anything you say won't be directly attributed to you, apart from if you disclose that either you or someone else may be in danger of being harmed. In this instance the information will be passed on to the appropriate authority. Something you say may be included in the report as a direct quote, but with no attribution as to who said it.

With your permission, I will be recording today's interview so that I have an accurate record of what you tell me. The recordings will be destroyed as soon as I've completed my analysis of the interviews.

### **Questions**

- i) What is your job title?
- ii) Which organisation do you work in?
- iii) How long have you worked in health / social care?
- iv) When did you attend the Provider Manager/ Team Leader Workshop?
- v) Have you ever made a Safeguarding Adults alert?
- vi) Have you ever been involved in a Safeguarding investigation in any capacity?

- 1) What were your reasons for attending the Provider Manager/ Team Leader workshop?
- 2) Before you attended the Provider Manager/ Team Leader workshop, were you asked to complete any preparation work?

(if yes)

- 2a) What were your first impressions of this task?
- 2b) How useful did you find it, and why?

2c) Is there any way you think it could be made more useful or otherwise improved?

- 3) Thinking about the workshop now; can you remember what your overall impressions of the workshop were at the end of the first day?
- 4) What did you think of the second half day session?
- 5) How useful was attending the workshop in terms of affecting or improving what you do at work?
- 6) What impact do you think the Provider Manager/ Team Leader workshop has had on your work? Can you give any examples?

Prompts:

- a) Working with other staff
- b) Working with people who use your service
- c) Impact on policies/ procedures
- d) Impact on your attitudes
- e) Impact on actions you have taken or modified
- f) Any other impacts?

6a) How many people do the changes affect?

- 7) What aspects of the training if any- particular activities, presentations or materials- do you think assisted you to transfer your learning to your workplace? (Provide workshop lesson plan as a reminder)
- 8) Has anything in your workplace helped or hindered you to transfer your learning?

Prompts:

- a) Peer/ colleague support
  - b) Managerial support
  - c) Availability of resources such as time and opportunity, other staff?
  - d) Supervision
  - e) Discussion in team meeting
  - f) New knowledge, media reports, books
  - g) Involvement in the evaluation
- 
- 9) How could the training be improved to better assist you to transfer your learning?
  - 10) The workshop was multiagency. What advantages or disadvantages do you feel a multiagency session has?
  - 11) Can you think of any support after a training event that might help you to make better use of your learning at work?
  - 12) Finally, what support do you as a manager / team leader offer to your staff to implement the learning and development that they attend?
  - 13) That was my last question. Would you like to add anything else?

Thank you very much for your participation.

## Appendix M Interview script: Human Rights workshop

### Interview Script- Human Rights workshop

#### Preamble

The purpose of this interview is to gain a more in depth understanding of:

The impact that the Human Rights workshop has had on your practice

- Your experiences of the workshop in terms of transferring learning to your workplace (e.g. how the workshop has affected what you do at work)
- Whether anything in the workshop, or in your workplace helped or hindered you in using the new learning in your work.

I have several main questions which you have already received, and I expect it will take us between half an hour and an hour to complete them.

The information you provide me with today will remain completely confidential to the extent that anything you say won't be directly attributed to you, apart from if you disclose that either you or someone else may be in danger of being harmed. In this instance the information will be passed on to the appropriate authority. Something you say may be included in the report as a direct quote, but with no attribution as to who said it.

With your permission, I will be recording today's interview so that I have an accurate record of what you tell me. The recordings will be destroyed as soon as I've completed my analysis of the interviews.

#### Questions

- i) What is your job title?
- ii) Which organisation do you work in?
- iii) How long have you worked in health / social care?
- iv) When did you attend the Human Rights workshop?
- v) Have you ever made a Safeguarding Adults alert?
- vi) Have you ever been involved in a Safeguarding investigation in any capacity?

- 1) What were your reasons for attending the Human Rights workshop?
- 2) Before you attended the Human Rights workshop, were you asked to complete any preparation work? (show form)

(if yes)

- 2a) What were your first impressions of this task?
- 2b) How useful did you find it, and why?
- 2c) Is there any way you think it could be made more useful or otherwise improved?

- 3) Thinking about the workshop now; can you remember what your overall impressions of the workshop were at the end of the day?
- 4) How useful was attending the workshop in terms of affecting or improving what you do at work?
- 5) Have you used the learning logs and action plans since the training? How helpful have they been? (Prompt person to refer to LL and AP if they've brought them)
- 6) What impact do you think the Human Rights training has had on your practice, as in what you do at work? Can you give any examples?

Prompts:

- g) Working with other staff
  - h) Working with people who use your service
  - i) Impact on your attitudes
  - j) Impact on actions you have taken or modified
  - k) Any other impacts?
- 
- 7) What aspects of the training if any- particular activities, presentations or materials- do you think assisted you to transfer your learning to your workplace? (Provide workshop lesson plan as a reminder)
  - 8) Has anything in your workplace helped or hindered you to transfer your learning?

Prompts:

- h) Peer/ colleague support
  - i) Managerial support
  - j) Availability of resources such as time and opportunity, other staff?
  - k) Supervision
  - l) Discussion in team meeting
  - m) New knowledge, media reports, books
  - n) Involvement in the evaluation
- 
- 9) How could the training be improved to better assist you to transfer your learning?
  - 10) Can you think of any support after a training event that might help you to make better use of your learning at work?
  - 11) That was my last question. Would you like to add anything else?

Thank you very much for your participation.

## Appendix N Interview script: Training professional

### Interview Script- Training Professional

#### Preamble

The purpose of this interview is to gain a more in depth understanding of:

- The impact that you feel Safeguarding Adults training has on delegates' practice
- The factors in the workshop, or delegates' workplaces, that may help or hinder the transfer of their learning to their work

I have several main questions which you have already received, and I expect it will take us between half an hour and an hour to complete them.

The information you provide me with today will remain completely confidential to the extent that anything you say won't be directly attributed to you, apart from if you disclose that either you or someone else may be in danger of being harmed. In this instance the information will be passed on to the appropriate authority. Something you say may be included in the report as a direct quote, but with no attribution as to who said it.

With your permission, I will be recording today's interview so that I have an accurate record of what you tell me. The recordings will be destroyed as soon as I've completed my analysis of the interviews.

#### Questions

- i) What is your job title?
  - ii) Which organisation do you work in?
  - iii) Have you ever worked as a health/ social care practitioner?
  - iv) How long have you worked as a trainer?
  - v) Which sessions do you facilitate?
- 
- 1) Delegates are asked to complete preparation work for both the Human Rights and Provider Manager workshop. How many people on average do you think complete it?
  - 2) How beneficial do you think the preparation work is as an exercise?
  - 3) How do you think preparation can be made most effective?
  - 4) Thinking about the Human Rights workshop now; what has the reaction of delegates been so far to the day?
  - 5) How much use is made of tools like learning logs and action plans?
  - 6) What impact do you think the workshop has on delegates' work?
  - 7) How do you think the impact of the workshop can or should be evaluated?

- 8) Thinking about the Provider Manager session now; how has the change in format to a day and a half been received by delegates?
- 9) What impact do you think the Provider Manager/ Team Leader workshop has had on delegates work? Can you give any examples?

Prompts:

- l) Working with other staff
- m) Working with people who use their service
- n) Impact on policies/ procedures
- o) Impact on your attitudes
- p) Impact on actions you have taken or modified
- q) Any other impacts?

9a) How many people on average do the changes effect?

- 10) What aspects of either workshop- particular activities, presentations or materials- do you think assists delegates to transfer their learning to their workplace?
- 11) Thinking about discussions in training, what factors in the workplace are identified as helpful or unhelpful to improving Safeguarding adults practice at work?

Prompts:

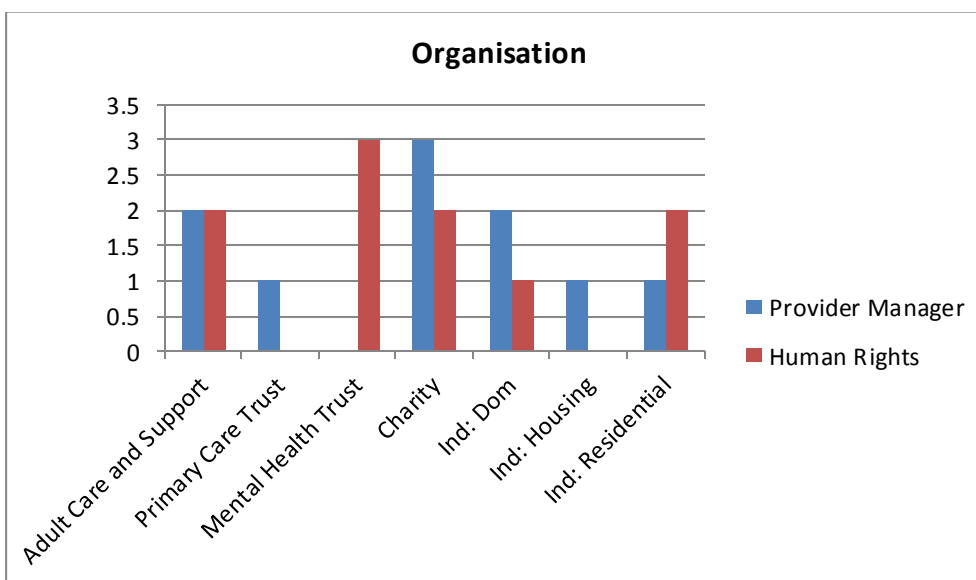
- o) Peer/ colleague support
  - p) Managerial support
  - q) Availability of resources such as time and opportunity, other staff?
  - r) Supervision
  - s) Discussion in team meeting
  - t) New knowledge, media reports, books
- 12) The workshops are multiagency, as recommended by *No Secrets*. What advantages or disadvantages do you feel a multiagency session has?
  - 13) Do you think the sessions should remain multiagency?
  - 14) Can you think of any support that your department could offer or recommend to delegates that might help them to make better use of their learning at work?
  - 15) Lastly, how effective do you think training is as a tool to promote Safeguarding Adults? Are there alternatives to training that could be used instead/ as well as?
  - 16) That was my last question. Would you like to add anything else?

Thank you very much for your participation.

## Appendix O Interview study participant demographics

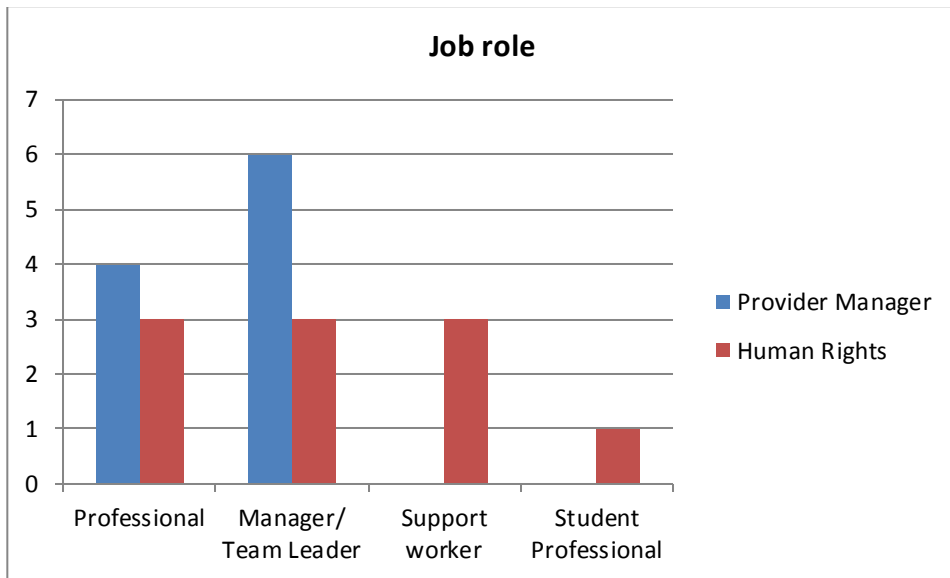
### 0.1. Organisation

	Provider Manager	Human Rights
Adult Care and Support	2	2
Primary Care Trust	1	0
Mental Health Trust	0	3
Charity	3	2
Ind: Dom	2	1
Ind: Housing	1	0
Ind: Residential	1	2



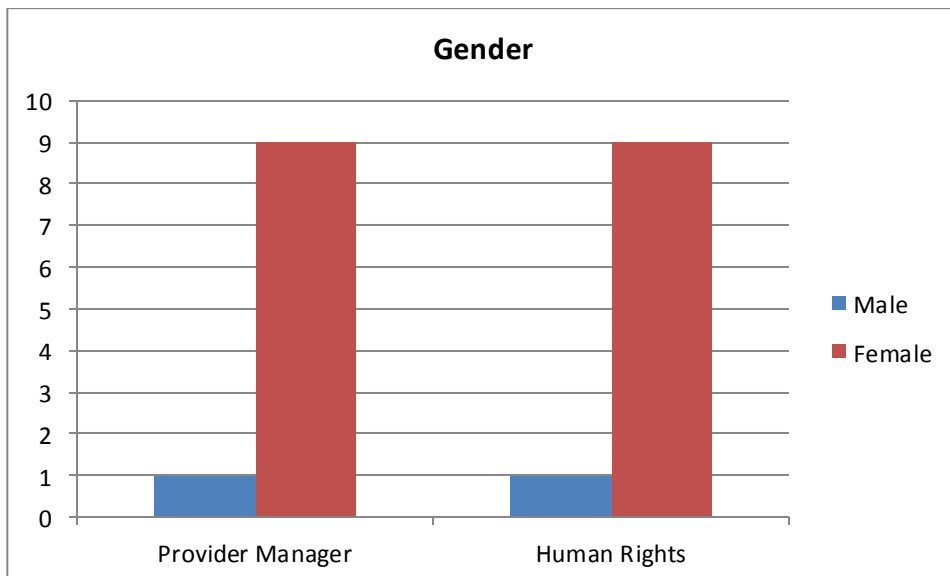
### 0.2. Job role

	Provider Manager	Human Rights
Professional	4	3
Manager/ Team Leader	6	3
Support worker	0	3
Student Professional	0	1



0.3. *Gender*

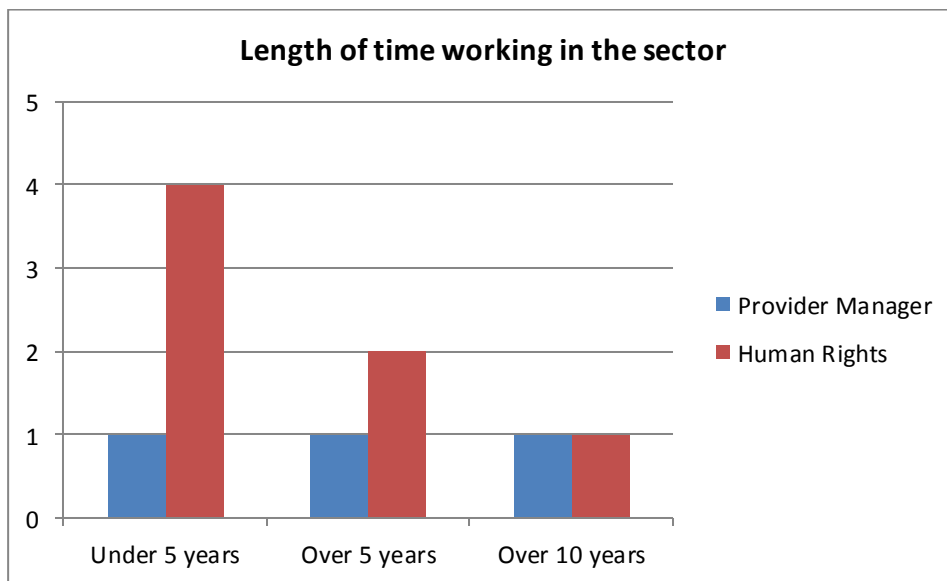
	Provider Manager	Human Rights
<b>Male</b>	1	1
<b>Female</b>	9	9





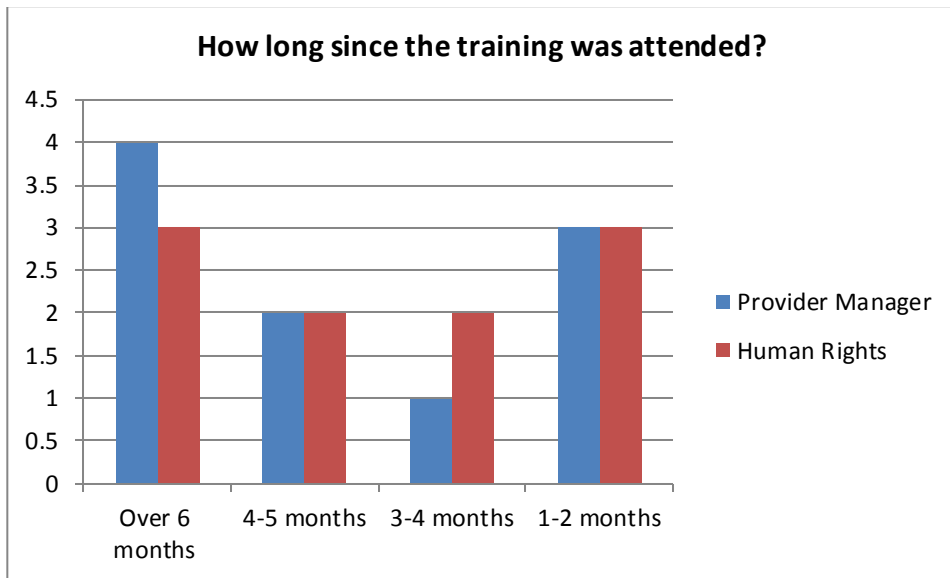
0.4. *Length of time working in the sector*

	Provider Manager	Human Rights
Under 5 years	1	4
Over 5 years	1	2
Over 10 years	1	1
Over 15 years	2	1
Over 20 years	2	0
Over 25 years	3	2



0.5. *Length of time since the training was attended*

	Provider Manager	Human Rights
Over 6 months	4	3
4-5 months	2	2
3-4 months	1	2
1-2 months	3	3



0.6. *Past involvement in safeguarding adults*

	Provider Manager	Human Rights
Made alert	6	2
Involved in Safeguarding	7	4



## Appendix P Ethics documentation

### *P.1. Ethical Approval: University of Plymouth*



MS/ab

4<sup>th</sup> October 2010

#### **CONFIDENTIAL**

Ms Lindsey Pike  
23 Norfolk Road  
Falmouth  
Cornwall  
TR11 4NT

#### **Faculty of Health**

University of Plymouth  
  
Drake Circus  
  
Plymouth PL4 8AA

Dear Lindsey

#### ***Application Title: Investigation into Safeguarding Adults training transfer in Health and Social Care***

Thank you for applying to the ethics committee for approval. Further to receiving your amendments to your application, I am pleased to inform you that the Committee has granted approval to you to conduct this research.

Please note that this approval is for three years, after which you will be required to seek extension of existing approval.

Please note that should any MAJOR changes to your research design occur which effect the ethics of procedures involved you must inform the Committee. Please contact Alison Bendall on (01752) 586703 or by email [alison.bendall@plymouth.ac.uk](mailto:alison.bendall@plymouth.ac.uk)

Yours sincerely

Professor Michael Sheppard, PhD, AcSS,  
Chair, Research Ethics Committee  
Faculty of Health  
University of Plymouth



## National Research Ethics Service

### South West 1 Research Ethics Committee

John Apley Building  
Room 11  
Royal United Hospital  
Combe Park  
Bath  
BA1 3NG

Telephone: 01225 824255

Facsimile: 01225 825725

e-mail: [kirsten.peck@ruh-bath.swest.nhs.uk](mailto:kirsten.peck@ruh-bath.swest.nhs.uk)

13 September 2010

Ms Lindsey Pike  
23 Norfolk Road  
Falmouth  
Cornwall  
TR113NT

Dear Ms Pike

**Study Title:** Investigation into Safeguarding Adults training transfer  
in Health and Social Care  
**REC reference number:** 10/H0203/51

Thank you for your letter of 01 September 2010, 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>.

This Research Ethics Committee is an advisory committee to South West Strategic Health Authority  
The National Research Ethics Service (NRES) represents the NRES Directorate within  
the National Patient Safety Agency and Research Ethics Committees in England

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:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Investigator CV		07 July 2010
Protocol	8	01 June 2010
CV - William Sheaff		01 August 2009
interview script - training professional	1	31 August 2010
REC application	3.0	03 July 2008
Covering Letter		07 July 2010
Letter from Sponsor		07 July 2010
Advertisement	2	31 August 2010
Participant Information Sheet: Vignette study	3	31 August 2010
Response to Request for Further Information		01 September 2010
Participant Information Sheet: Training Professional interview	3	31 August 2010
Participant Information Sheet: Provider Manager workshop	3	31 August 2010
Participant Information Sheet: Human Rights Workshop interviews	3	31 August 2010
Participant Consent Form: Vignette study	2	31 August 2010
Participant Consent Form: Training professional	2	31 August 2010
Participant Consent Form: human Rights Workshop	2	31 August 2010
Participant Consent Form: provider Manager Safeguarding adults training	2	31 August 2010
Statement of progress		
Interview script - Human Rights Workshop	1	31 August 2010
Interview Script - Provider Manager/Team Leader Workshop	1	31 August 2010
Vignetter study: Questions and structure	1	31 August 2010
Evidence of insurance or indemnity		05 August 2009
Referees or other scientific critique report		

#### 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](mailto:referencegroup@nres.npsa.nhs.uk).

<b>REC reference 10/H0203/51</b>	<b>Please quote this number on all correspondence</b>
----------------------------------	---

Yours sincerely



pp **Canon Ian Ainsworth-Smith**  
**Chair**  
**South West 1 Research Ethics Committee**

Enclosures: "After ethical review – guidance for researchers"

Copy to: Richard Stephenson Room 208 Nancy Astor Building Drake Circus Plymouth PL4 8AA

## **RESEARCH IN HUMAN SUBJECTS OTHER THAN CLINICAL TRIALS OF INVESTIGATIONAL MEDICINAL PRODUCTS**

### **After ethical review – guidance for sponsors and investigators**

This document sets out important guidance for sponsors and investigators on the conduct and management of research with a favourable opinion from a NHS Research Ethics Committee. Please read the guidance carefully. A failure to follow the guidance could lead to the committee reviewing its opinion on the research.

1. Further communications with the Research Ethics Committee
  - 1.1 Further communications during the research with the Research Ethics Committee that gave the favourable ethical opinion (hereafter referred to in this document as “the Committee”) are the personal responsibility of the Chief Investigator.
  
2. Commencement of the research
  - 2.1 It is assumed that the research will commence within 12 months of the date of the favourable ethical opinion.
  - 2.2 The research must not commence at any site until the local Principal Investigator (PI) or research collaborator has obtained management permission or approval from the organisation with responsibility for the research participants at the site.
  - 2.3 Should the research not commence within 12 months, the Chief Investigator should give a written explanation for the delay
  - 2.4 Should the research not commence within 24 months, the Committee may review its opinion.
  
3. Duration of ethical approval
  - 3.1 The favourable opinion for the research generally applies for the duration of the research. If it is proposed to extend the duration of the study as specified in the application form, the Committee should be notified.



3.2 Where the research involves the use of “relevant material” for the purposes of the Human Tissue Act 2004, authority to hold the material under the terms of the ethical approval applies until the end of the period declared in the application and approved by the Committee.

#### 4. Progress reports

4.1 Research Ethics Committees are expected to keep a favourable opinion under review in the light of progress reports and any developments in the study. The Chief Investigator should submit a progress report to the Committee 12 months after the date on which the favourable opinion was given. Annual progress reports should be submitted thereafter.

4.2 Progress reports should be in the format prescribed by NRES and published on the website (see [www.nres.npsa.nhs.uk/applicants/after-ethical-review/](http://www.nres.npsa.nhs.uk/applicants/after-ethical-review/)).

4.3 The Chief Investigator may be requested to attend a meeting of the Committee or Sub-Committee to discuss the progress of the research.

#### 5. Amendments

5.1 If it is proposed to make a substantial amendment to the research, the Chief Investigator should submit a notice of amendment to the Committee.

5.2 A substantial amendment is any amendment to the terms of the application for ethical review, or to the protocol or other supporting documentation approved by the Committee, that is likely to affect to a significant degree:

- (a) the safety or physical or mental integrity of the trial participants
- (b) the scientific value of the trial
- (c) the conduct or management of the trial.

5.3 Notices of amendment should be in the format prescribed by NRES and published on the website, and should be personally signed by the Chief Investigator. The agreement of the sponsor should be sought before submitting the notice of amendment.

5.4 A substantial amendment should not be implemented until a favourable ethical opinion has been given by the Committee, unless the changes to the research are urgent safety measures (see section 7). The Committee is required to give an opinion within 35 days of the date of receiving a valid notice of amendment.

5.5 Amendments that are not substantial amendments (“minor amendments”) may be made at any time and do not need to be notified to the Committee.

#### 6. Changes to sites

*Management permission (all studies)*

- 6.1 For all studies, management permission should be obtained from the host organisation where it is proposed to:
- include a new site in the research, not included in the list of proposed research sites in the original REC application
  - appoint a new PI or Local Collaborator at a research site
  - make any other significant change to the conduct or management of a research site.

In the case of any new NHS site, the Site-Specific Information (SSI) Form should be submitted to the R&D office for review as part of the R&D application.

*Site-specific assessment (where required)*

- 6.2 The following guidance applies only to studies requiring site-specific assessment (SSA) as part of ethical review.
- 6.3 In the case of NHS/HSC sites, SSA responsibilities are undertaken on behalf of the REC by the relevant R&D office as part of the research governance review. The Committee's favourable opinion for the study will apply to any new sites and other changes at sites provided that management permission is obtained. There is no need to notify the Committee (or any other REC) about new sites or other changes, or to provide a copy of the SSI Form.
- 6.4 Changes at non-NHS sites require review by the local REC responsible for site-specific assessment (SSA REC). Please submit the SSI Form (or revised SSI Form as appropriate) to the SSA REC together with relevant supporting documentation. The SSA REC will advise the main REC whether it has any objection to the new site/PI or other change. The main REC will notify the Chief Investigator and sponsor of its opinion within a maximum of 35 days from the date on which a valid SSA application has been received by the SSA REC.

*Studies not requiring SSA*

- 6.5 For studies designated by the Committee as not requiring SSA, there is no requirement to notify the Committee of the inclusion of new sites or other changes at sites, either for NHS or non-NHS sites. However, management permission should still be obtained from the responsible host organisation (see 6.1 above).

7. Urgent safety measures

- 7.1 The sponsor or the Chief Investigator, or the local Principal Investigator at a trial site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety.
- 7.2 The Committee must be notified within three days that such measures have been taken, the reasons why and the plan for further action.

8. Serious Adverse Events

- 8.1 A Serious Adverse Event (SAE) is an untoward occurrence that:
- (a) results in death
  - (b) is life-threatening
  - (c) requires hospitalisation or prolongation of existing hospitalisation
  - (d) results in persistent or significant disability or incapacity
  - (e) consists of a congenital anomaly or birth defect
  - (f) is otherwise considered medically significant by the investigator.
- 8.2 A SAE occurring to a research participant should be reported to the Committee where in the opinion of the Chief Investigator the event was related to administration of any of the research procedures, and was an unexpected occurrence.
- 8.3 Reports of SAEs should be provided to the Committee within 15 days of the Chief Investigator becoming aware of the event, in the format prescribed by NRES and published on the website.
- 8.4 The Chief Investigator may be requested to attend a meeting of the Committee or Sub-Committee to discuss any concerns about the health or safety of research subjects.
- 8.5 Reports should not be sent to other RECs in the case of multi-site studies.
9. Conclusion or early termination of the research
- 9.1 The Chief Investigator should notify the Committee in writing that the research has ended within 90 days of its conclusion. The conclusion of the research is defined as the final date or event specified in the protocol, not the completion of data analysis or publication of the results.
- 9.2 If the research is terminated early, the Chief Investigator should notify the Committee within 15 days of the date of termination. An explanation of the reasons for early termination should be given.
- 9.3 Reports of conclusion or early termination should be submitted in the form prescribed by NRES and published on the website.
10. Final report
- 10.1 A summary of the final report on the research should be provided to the Committee within 12 months of the conclusion of the study. This should include information on whether the study achieved its objectives, the main findings, and arrangements for publication or dissemination of the research including any feedback to participants.
11. Review of ethical opinion
- 11.1 The Committee may review its opinion at any time in the light of any relevant information it receives.

- 11.2 The Chief Investigator may at any time request that the Committee reviews its opinion, or seek advice from the Committee on any ethical issue relating to the research.

P.3. *Ethical Approvals: Letter of access*

Cornwall Partnership 

NHS Foundation Trust

**Research and Development Directorate**

R&D Director	01872 256437
Research Manager	01872 256424
Assistant Research Manager	01872 256422
Clinical Trials Co-ordinator	01872 256423
R&D Office Manager	01872 256428
Research Support & CSP Officers	01872 256427/1
Research Support Administrator	01872 256420

  
**Cornwall and Isles of Scilly**

Royal Cornwall Hospitals 

NHS Trust

The Knowledge Spa

Royal Cornwall Hospitals NHS Trust

Truro

Cornwall

TR1 3HD

9 December 2010

Ms Lindsey Pike  
23 Norfolk Road  
Falmouth TR11 3NT

Dear Ms Pike

**Re: 2010.CPT.13, 2010.PCT. 22, 2010.RCHT.52**  
**Investigation into Training Transfer in Health & Social Care**

I am pleased to confirm that the condition(s) listed in the conditional approval letters, for the above study, have now been met and full Trust approval applies to your study in the Royal Cornwall Hospitals Trust, Cornwall Partnership Trust and Cornwall & Isles of Scilly Primary Care Trust.

**Research Governance**

I would like to take this opportunity to remind you of your responsibilities as a Principal Investigator. These are:

1. Work must be carried out in line with Good Clinical Practice and the Research Governance Framework for Health and Social Services, which details the responsibilities for everyone involved in research
2. The Data Protection Act 1998 requires you to follow the eight principles of 'good information handling'
3. To provide information when requested for Trust research governance monitoring and auditing purposes
4. You must be aware of, and comply with, Health and Safety standards in relation to your research

For further information, please contact the Research and Development Directorate or visit [www.dh.gov.uk](http://www.dh.gov.uk)

**Adverse Events**

Can I remind you that you must immediately report to the Research and Development Directorate any serious adverse event occurring during the study quoting the study reference number.

**Outcome and Publications**

Please keep the Research and Development Directorate informed of your progress to allow accurate submissions to the Department of Health in our Annual Report. You must also submit to the Research & Development Directorate a final outcome report on

completion of your study. If you publish, please send a copy to the Directorate using the address above.

Yours sincerely

A handwritten signature in black ink, appearing to read 'S. Brown', written over a horizontal line.

Scott Brown  
Research Manager

cc *Bianca Mills*  
*Susannah Tooth*  
*Sponsor*  
*All supporting services*

P.4. Ethical Approval: Cornwall Council

The screenshot shows a webmail interface in a browser window. The address bar displays a URL from webmail.plymouth.ac.uk. The email title is "RE: Confirmation of RGF" from Omlo-Coad Magi. The sender is Lindsey Pike, dated 18 November 2010. The email content includes a greeting, an apology for a delay, and contact information for Cornwall Council. A yellow banner at the top of the email body indicates that a read receipt was requested.

Web Access: Type here to search | This Folder

Reply | Reply to All | Forward | Move | Delete | Junk | Close

**RE: Confirmation of RGF**  
Omlo-Coad Magi [momlocoad@cornwall.gov.uk]

The sender of this message has requested a read receipt. [Click here to send a receipt.](#)

Sent: 18 November 2010 08:34  
To: Lindsey Pike

Hi there

Sorry for the delay this is just an e mail to say please carry on with the project that you recently submitted to the RGF panel

Many thanks

Magi Omlo-Coad  
Research & Consultation Officer  
Adult Care & Support  
Communications & Customer Relations Team  
Cornwall Council  
Tel: 01872 32 3641  
Mobile: 07973 497397  
momlocoad@cornwall.gov.uk

Room 723, Old County Hall, Station Road, Truro TR1 3AY  
[www.cornwall.gov.uk](http://www.cornwall.gov.uk)

Please let us know if you need any particular assistance from us, such as facilities to help with mobility, vision or hearing, or information in a different format

Please consider the environment. Do you really need to print this e mail.

-----Original Message-----

*P.5. Consent form: vignettes*

**Consent form**

**Investigation into training transfer in health and social care:**

**Vignette study. Principle Investigator: Lindsey Pike**

Please indicate that you give your informed consent to participating in this study. This sheet will not be stored with or linked to your answers.

	Please initial box
I confirm that I have read and understand the information sheet dated August 2010 (version 3) for the above study. I have had the opportunity to consider the information ask questions and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason without my current or future employment being affected.	
I have read and understood the information sheet and agree to participate in this study.	
I understand that my participation will remain anonymous unless I disclose a safeguarding issue in which case the researcher may make a Safeguarding alert to Adult Care and Support under the relevant local policy, or signpost me to support to do so.	

.....  
 Name of Participant                      Date                      Signature

.....  
 Name of Researcher                      Date                      Signature

For entry into Prize Draw: (please write clearly!)

Name                      .....

Phone Number                      .....

Email address                      .....

If you would like to receive a summary of the findings of this research via email, please write your contact details below.

.....



**Consent form**

**Investigation into training transfer in health and social care:**

**Interview- Provider Manager Safeguarding Adults training**

**Principle Investigator: Lindsey Pike**

Please indicate that you give your informed consent to participating in this study. This sheet will not be stored with or linked to your answers.

	Please initial box
I confirm that I have read and understand the information sheet dated August 2010 (version 3) for the above study. I have had the opportunity to consider the information ask questions and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason without my current or future employment being affected.	
I have read and understood the information sheet and agree to participate in this study.	
I understand that my participation will remain anonymous unless I disclose a safeguarding issue in which case the researcher may make a Safeguarding alert to Adult Care and Support under the relevant local policy, or signpost me to support to do so.	

.....  
 Name of Participant                      Date                      Signature

.....  
 Name of Researcher                      Date                      Signature

For entry into Prize Draw: (please write clearly!)

Name                      .....

Phone Number                      .....

Email address                      .....

If you would like to receive a summary of the findings of this research via email, please write your contact details below.

.....

**Consent form**

**Investigation into training transfer in health and social care:**

**Interview- Human Rights workshop**

**Principle Investigator: Lindsey Pike**

Please indicate that you give your informed consent to participating in this study. This sheet will not be stored with or linked to your answers.

	Please initial box
I confirm that I have read and understand the information sheet dated August 2010 (version 3) for the above study. I have had the opportunity to consider the information ask questions and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason without my current or future employment being affected.	
I have read and understood the information sheet and agree to participate in this study.	
I understand that my participation will remain anonymous unless I disclose a safeguarding issue in which case the researcher may make a Safeguarding alert to Adult Care and Support under the relevant local policy, or signpost me to support to do so.	

.....  
 Name of Participant                      Date                      Signature

.....  
 Name of Researcher                      Date                      Signature

For entry into Prize Draw: (please write clearly!)

Name                      .....

Phone Number                      .....

Email address                      .....

If you would like to receive a summary of the findings of this research via email, please write your contact details below.

.....

**Consent form**

**Investigation into training transfer in health and social care:**

**Interview- Training Professional**

**Principle Investigator: Lindsey Pike**

Please indicate that you give your informed consent to participating in this study. This sheet will not be stored with or linked to your answers.

	Please initial box
I confirm that I have read and understand the information sheet dated August 2010 (version 3) for the above study. I have had the opportunity to consider the information ask questions and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason without my current or future employment being affected.	
I have read and understood the information sheet and agree to participate in this study.	
I understand that my participation will remain anonymous unless I disclose a safeguarding issue in which case the researcher may make a Safeguarding alert to Adult Care and Support under the relevant local policy, or signpost me to support to do so.	

.....  
 Name of Participant                      Date                      Signature

.....  
 Name of Researcher                      Date                      Signature

For entry into Prize Draw: (please write clearly!)

Name                      .....

Phone Number                      .....

Email address                      .....

If you would like to receive a summary of the findings of this research via email, please write your contact details below.

.....

## Information about the research

### Investigation into training transfer in health and social care: vignette study

I would like to invite you to take part in my PhD research study. Before you decide, I would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you may have when we meet- this should take about 5 minutes.

#### AIM OF THE STUDY

This research is aiming to find out whether attending the Human Rights workshop or Provider Manager Safeguarding Adults training has any impact on the circumstances in which people would make a Safeguarding Adults alert.

#### WHY HAVE I BEEN INVITED TO TAKE PART?

People who work or volunteer in Health, Social Care or other sectors in Cornwall with Safeguarding Adults as a concern have been invited to take part. About 150 people will be recruited in total.

#### DO I HAVE TO TAKE PART?

It's entirely up to you if you join the study. If you agree to take part, you will be asked to sign a consent form. You are free to withdraw from the study at any time without giving a reason. Withdrawing from the study, or deciding not to participate, will have no adverse effect on your current or future employment.

#### WHAT WILL I HAVE TO DO?

You will be asked to answer some questions about the actions you would take after reading a vignette, which is a hypothetical scenario. You'll be asked to read 8 vignettes in total, and together with answering the questions it should take about 10-20 minutes to complete. The scenarios are all different but sometimes the differences are only very slight, so please read them carefully.

The vignettes will be presented on a laptop screen; if you need assistance using a computer the researcher will be happy to help.

#### WHY SHOULD I PARTICIPATE?

Your participation would help us find out more about the factors that encourage or dissuade people from making alerts, and whether Safeguarding Adults training has any effect on them. You will also have the opportunity to be entered into a **prize draw** for vouchers of your choice, funded by the University of Plymouth; 1<sup>st</sup> prize £50, 2<sup>nd</sup> prize £20, 3<sup>rd</sup> prize £10.

## WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART?

You will be offered access to the findings when they are written up (this may be in a few years' time), which may develop your understanding of training transfer.

## WILL MY TAKING PART BE KEPT CONFIDENTIAL?

Yes. The study will not request any personal details (e.g. name, workplace) although it will ask you for information such as your job title and how long you've worked in Health or Social Care. Your answers will not be identifiable to you in any way. However if you disclose a safeguarding issue, the researcher may either report it under the Cornwall and Isles of Scilly Safeguarding Adults Multiagency Policy, or signpost you to support to do so.

## HOW WILL THE FINDINGS BE USED AND REPORTED?

The findings of this research will be used to:

- Inform a PhD which is based at the University of Plymouth.
- Inform the Learning Training and Development Unit and its multiagency partners about the effectiveness of the Human Rights workshop
- Inform the Safeguarding Adults Unit and Safeguarding Adults Board of factors that influence whether an alert is made or not

They will be published as part of a PhD thesis, and possibly in journal articles.

## FUNDING AND REVIEW

This research is being funded by a Graduate School Scholarship from the University of Plymouth, and has been reviewed and given a favourable ethical opinion by Plymouth NHS, the University of Plymouth, and Cornwall Council's Research Ethics Committees.

## WHO CAN I CONTACT FOR FURTHER INFORMATION?

If you would like to find out more, report a concern or clarify anything, please contact Lindsey Pike at:

Email: [Lindsey.pike@plymouth.ac.uk](mailto:Lindsey.pike@plymouth.ac.uk)

Phone: 07814 843903

Or her Director of Studies, Prof Rod Sheaff at

Email: [Rod.Sheaff@plymouth.ac.uk](mailto:Rod.Sheaff@plymouth.ac.uk)

Phone: 01752

586652

## Information about the research

### Investigation into training transfer in health and social care: Provider Manager workshop interviews

I would like to invite you to take part in my PhD research study. Before you decide, I would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you may have when we meet- this should take about 5 minutes.

#### AIM OF THE STUDY

This research is aiming to find out the effects, in terms of attitudes, knowledge and actions, of the Provider Manager/ Team Leader Safeguarding Adults workshop. It is also investigating the factors in the workshop, and in your workplace, that have either helped or hindered the use of learning from the workshop in your workplace.

#### WHY HAVE I BEEN INVITED TO TAKE PART?

People who work or volunteer in Health, Social Care or other sectors in Cornwall with Safeguarding Adults as a concern have been invited to take part. About 10 people will be recruited for interviews about the Provider Manager/ Team Leader workshop.

#### DO I HAVE TO TAKE PART?

It's entirely up to you if you join the study. If you agree to take part, you will be asked to sign a consent form. You are free to withdraw from the study at any time without giving a reason. Withdrawing from the study, or deciding not to participate, will have no adverse effect on your current or future employment.

#### WHAT WILL I HAVE TO DO?

You will be interviewed by the researcher, who will ask you about your experiences of the workshop and how it has affected what you do at work (if at all). She will also ask you about what has helped or hindered you in applying what you have learnt to practice.

#### WHY SHOULD I PARTICIPATE?

Your participation will help us find out more about the factors that making Safeguarding Adults training effective, which may contribute to the wellbeing of vulnerable adults in Cornwall and beyond.

You will also have the opportunity to be entered into a **prize draw** for vouchers of your choice, funded by the University of Plymouth; 1<sup>st</sup> prize £50, 2<sup>nd</sup> prize £20, 3<sup>rd</sup> prize £10.

#### WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART?

You will be offered access to the findings when they are written up (this may be in a few years' time), which may develop your understanding of training transfer.

#### WILL MY TAKING PART BE KEPT CONFIDENTIAL?

Yes. The study will not request any personal details (e.g. name, workplace) although it will ask you for information such as your job title and how long you've worked in Health or Social Care. Your answers will not identify you or your workplace in any way. However if you disclose a safeguarding issue, the researcher may either report it under the Cornwall and Isles of Scilly Safeguarding Adults Multiagency Policy, or signpost you to support to do so.

#### HOW WILL THE FINDINGS BE USED AND REPORTED?

The findings of this research will be used to:

- Inform a PhD which is based at the University of Plymouth.
- Inform the Learning Training and Development Unit and its multiagency partners about the effectiveness of the Human Rights workshop
- Inform the Safeguarding Adults Unit and Safeguarding Adults Board of factors that influence whether an alert is made or not

Findings will be published as part of a PhD thesis, and possibly in journal articles.

#### FUNDING AND REVIEW

This research is being funded by a Graduate School Scholarship from the University of Plymouth, and has been reviewed and given a favourable ethical opinion by Plymouth NHS Research Ethics Committee.

#### WHO CAN I CONTACT FOR FURTHER INFORMATION?

If you would like to find out more, report a concern or clarify anything, please contact Lindsey Pike at:

Email: [Lindsey.pike@plymouth.ac.uk](mailto:Lindsey.pike@plymouth.ac.uk)

Phone: 07814 843903

Or her Director of Studies, Prof Rod Sheaff at

Email: [Rod.Sheaff@plymouth.ac.uk](mailto:Rod.Sheaff@plymouth.ac.uk)

Phone: 01752 586652

## Information about the research

Investigation into training transfer in health  
and social care: Human Rights workshop interviews

I would like to invite you to take part in my PhD research study. Before you decide, I would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you may have when we meet- this should take about 5 minutes.

### AIM OF THE STUDY

This research is aiming to find out the effects, in terms of attitudes, knowledge and actions, of the Human Rights workshop. It is also investigating the factors in the workshop, and in your workplace, that have either helped or hindered the use of learning from the workshop in your workplace.

### WHY HAVE I BEEN INVITED TO TAKE PART?

People who work or volunteer in Health, Social Care or other sectors in Cornwall with Safeguarding Adults as a concern have been invited to take part. About 10 people will be recruited for interviews about the Human Rights workshop.

### DO I HAVE TO TAKE PART?

It's entirely up to you if you join the study. If you agree to take part, you will be asked to sign a consent form. You are free to withdraw from the study at any time without giving a reason. Withdrawing from the study, or deciding not to participate, will have no adverse effect on your current or future employment.

### WHAT WILL I HAVE TO DO?

You will be interviewed by the researcher, who will ask you about your experiences of the workshop and how it has affected what you do at work (if at all). She will also ask you about what has helped or hindered you in applying what you have learnt to practice.

### WHY SHOULD I PARTICIPATE?

Your participation will help us find out more about the factors that making Safeguarding Adults training effective, which may contribute to the wellbeing of vulnerable adults in Cornwall and beyond.

You will also have the opportunity to be entered into a **prize draw** for vouchers of your choice, funded by the University of Plymouth; 1<sup>st</sup> prize £50, 2<sup>nd</sup> prize £20, 3<sup>rd</sup> prize £10.



## WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART?

You will be offered access to the findings when they are written up (this may be in a few years' time), which may develop your understanding of training transfer.

## WILL MY TAKING PART BE KEPT CONFIDENTIAL?

Yes. The study will not request any personal details (e.g. name, workplace) although it will ask you for information such as your job title and how long you've worked in Health or Social Care. Your answers will not identify you or your workplace in any way. However if you disclose a safeguarding issue, the researcher may either report it under the Cornwall and Isles of Scilly Safeguarding Adults Multiagency Policy, or signpost you to support to do so.

## HOW WILL THE FINDINGS BE USED AND REPORTED?

The findings of this research will be used to:

- Inform a PhD which is based at the University of Plymouth.
- Inform the Learning Training and Development Unit and its multiagency partners about the effectiveness of the Human Rights workshop
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Or her Director of Studies, Prof Rod Sheaff at

Email: [Rod.Sheaff@plymouth.ac.uk](mailto:Rod.Sheaff@plymouth.ac.uk)

Phone: 01752 586652

## Information about the research

### Investigation into training transfer in health and social care: Training Professional interview

I would like to invite you to take part in my PhD research study. Before you decide, I would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you may have when we meet- this should take about 5 minutes.

#### AIM OF THE STUDY

This research is aiming to find out your opinions of the effects, in terms of changes in attitudes, knowledge and actions, of the Safeguarding Adults training that you provide. It is also investigating the factors in the workshops, and in delegates' workplaces, that may either help or hinder the use of learning from the workshop in their workplace.

#### WHY HAVE I BEEN INVITED TO TAKE PART?

People who work or volunteer in Health, Social Care or other sectors in Cornwall with Safeguarding Adults as a concern have been invited to take part. About 10 people will be recruited for interviews about the Human Rights workshop.

#### DO I HAVE TO TAKE PART?

It's entirely up to you if you join the study. If you agree to take part, you will be asked to sign a consent form. You are free to withdraw from the study at any time without giving a reason. Withdrawing from the study, or deciding not to participate, will have no adverse effect on your current or future employment.

#### WHAT WILL I HAVE TO DO?

You will be interviewed by the researcher, who will ask you about your experiences of the workshop and how you think it has affected what delegates do at work. She will also ask you about what organisational factors you believe help or hinder the application of Safeguarding Adults learning to practice in health and social care.

#### WHY SHOULD I PARTICIPATE?

Your participation will help us find out more about the factors that making Safeguarding Adults training effective, which may contribute to the wellbeing of vulnerable adults in Cornwall and beyond.

You will also have the opportunity to be entered into a **prize draw** for vouchers of your choice, funded by the University of Plymouth; 1<sup>st</sup> prize £50, 2<sup>nd</sup> prize £20, 3<sup>rd</sup> prize £10.

## WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART?

You will be offered access to the findings when they are written up (this may be in a few years' time), which may develop your understanding of training transfer.

## WILL MY TAKING PART BE KEPT CONFIDENTIAL?

Yes. The study will not request any personal details (e.g. name, workplace) although it will ask you for information such as your job title and how long you've worked in Health or Social Care. Your answers will not identify you or your workplace in any way. However if you disclose a safeguarding issue, the researcher may either report it under the Cornwall and Isles of Scilly Safeguarding Adults Multiagency Policy, or signpost you to support to do so.

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The findings of this research will be used to:

- Inform a PhD which is based at the University of Plymouth.
- Inform the Learning Training and Development Unit and its multiagency partners about the effectiveness of the Human Rights workshop
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Findings will be published as part of a PhD thesis, and possibly in journal articles.

## FUNDING AND REVIEW

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Or her Director of Studies, Prof Rod Sheaff at

Email: [Rod.Sheaff@plymouth.ac.uk](mailto:Rod.Sheaff@plymouth.ac.uk)

Phone: 01752

586652



LTD app.

Mar 10

## Appendix Q Preparation for the Human Rights workshop

**This form is the first part of your training. It acts as preparation for the Human Rights workshop. On average, it has been found to take about 20 minutes to complete.**

It is important that you and your manager take some time to complete this form together, in order to ensure that you understand why you are attending this training and what to expect from it. Although ideally you should complete it with your manager, it's better to complete it on your own than not at all! Attending the Human Rights workshop is a way to improve practice, and will be most successful if:

- You know why you are attending, what to expect and think it will be useful
- You and your manager view training as part of a process of continuous improvement
- You consider ways of transferring learning into practice\* before attending
- Your manager supports you to use any newly learnt skills and knowledge in your workplace.

\* Transferring learning into practice refers to knowledge, skills or values developed in training (or other learning experiences) being used back in the workplace; applying new learning to your work. Evidence shows most learning from training is lost because learning transfer is not supported before or after training; this form aims to prevent this from happening.

It may be useful to make a copy of this form to refer back to in future supervision, to discuss whether your expectations about this training were met. Please bring your completed form along to the workshop, as it forms the basis of the introductory session.

Your line manager needs to sign this form after you complete it.

<b>Your name:</b>	
-------------------	--

<b>Organisation:</b>	
----------------------	--

**To attend the Human Rights workshop, you must have completed Induction level training in Safeguarding Adults, Equality and Diversity and Mental Capacity Act. Please state below how you can evidence this. (e.g. attendance on training, e-learning, learning and development from other sources).**

**What do you want to achieve from this training, and how will this have a positive effect on your work? (e.g. increased knowledge in particular areas, ways in which you may be better able to promote well being and diversity)**

**What does your manager expect you to bring back from this training?**

**What barriers do you think might prevent you from using this learning in your work, and how will you overcome them? (e.g. workplace culture, attitude to procedures, time pressures, degree of support)**

**What are the consequences of not attending this training?**

**What will you and your manager do after training to support, develop and measure any positive changes in your work resulting from you attending this training (e.g. follow up supervision, practice observation, discussion in team meetings)**

**Thank you very much for completing this form! To give us an idea of its practical application, please indicate:**

**How long it took you to complete:**

- 0-10mins**       **10-20mins**       **20-30mins**       **30-40mins**  
 **40-50mins**       **over 50mins**

**Whether you completed it with your manager:**

**Yes**

**No**

Signed: (Applicant).....

Date: .....

Signed: (Manager).....

Date: .....

Print: (Manager).....

(Course aims, objectives and content are on the next page)

## Human Rights Workshop -

### Aims, Objectives and Course Content

#### **Aims**

- To enable participants to apply knowledge of **Safeguarding Adults, Mental Capacity Act and Equality and Diversity** so that the human rights of each individual are protected and promoted effectively.
- To underpin the relevant dimensions of the NHS KSF and Social Care Standards at Level 3.

#### **Objectives**

By the end of the workshop delegates will have

- Evidence of their relevant knowledge and areas where further learning is required
- Used case studies and examples to:
  - *Practice identifying safeguarding, mental capacity and equality and diversity issues.*
  - *Describe and demonstrate ways in which appropriate policies, procedures and tools for challenging can be used effectively.*
- Recognised and listed ways in which they will apply the learning and practice in the workplace through construction of a SMART Action Plan.

#### **Course Content**

- Welcome & introductions; review of prep work
  - Learning into Action
- Human Rights Time Line- where do our human rights stem from?
- Knowledge Check, Case Studies 1 and 2 (revisiting and applying knowledge of Safeguarding Adults, Mental Capacity Act and Equality and Diversity)
  - BREAK
  - Case Study 3
  - LUNCH
  - DVD 1
- Allport's Scale of Prejudice
  - DVD 2
- Challenging, confronting and raising a concern
  - BREAK
  - Case Study 4 and 5
  - Quiz
- Action plans and Evaluation



## Appendix R      Preparation: Provider Manager workshop

PLEASE READ ALL OF THIS EMAIL, AS IT INCLUDES IMPORTANT INFORMATION AND ACTIONS FOR YOU TO TAKE BEFORE ATTENDING THE TRAINING.

Dear delegate,

**Re: Safeguarding Adults – A Managers/Team Leaders Perspective, date, venue.**

A place has been reserved on the above course for:

**XYZ**

(Please note, if you are not the person attending but are the point of contact for them, please could you pass this confirmation on to them.)

The session will start at **9.30 am** (registration and refreshments from 9.15) and is expected to finish at approximately **4.30 pm**. **Lunch will not be provided so you will need to make arrangements to provide your own lunch.**

There will also be a follow-up half-day session on **date (am)** at the same venue, a reminder will be sent nearer the time.

**In order to get the most out of the day and a half, please complete the following preparation before attending. This aims to refresh your knowledge of managers' roles and responsibilities in health and/ or social care (as applicable), which should enable you to attend the training with a clearer idea of what you need to learn from it.**

**Attached to this email are extracts from four documents:**

- **The NHS Knowledge and Skills framework**
- **Code of practice for social care workers (General Social Care Council)**
- **Adult social care management induction standards (produced by Skills for Care)**
- **National Occupational Standards for management.**

**Please read the documents relevant to you, and make a note of how they relate to your personal job role. You may find it useful to refer to your job description and person specification in order to do this, as it will help you to consider how far your job description mirrors the national requirements. The findings from this will be discussed as an introductory exercise on the first day.**

Also enclosed is a map of the venue. If you have any queries or special requirements please do not hesitate to contact me on the number below. **If you are no longer able to attend, please inform me, even if at very short notice, as we may be able to offer your place to someone else.**

Kind regards,

**Lucy Grumett**

Senior Admin Assistant

Learning, Training and Development

Adult Care and Support

01872 323671

[lgrumett@cornwall.gov.uk](mailto:lgrumett@cornwall.gov.uk)

[www.cornwall.gov.uk/asclearninganddevelopment](http://www.cornwall.gov.uk/asclearninganddevelopment).

## Appendix S Correlation matrix of demographic variables

Pearson Chi Square correlations were computed for each pair of demographic variables, and showed significant correlations for all but one pairing (Current Length and Job)

	Job, care worker vs. anc/admin	Age	Length <5years vs.>5 years	Current length <5 vs. >5 years	All training	Involved dichotomy y/n	Made alert dichotomy y/n
Job, care worker vs. anc/admin	-	9.483 Df=4 Sig=0.05	13.951 Df=1 Sig=0.000	2.406 Df=1 Sig=0.121	48.893 Df=4 Sig=0.000	28.347 Df=1 Sig=0.000	14.137 Df=1 Sig=0.000
Age		-	195.347 Df=4 Sig=0.000	61.660 Df=4 Sig=0.000	121.535 Df=16 Sig=0.000	132.178 Df=4 Sig=0.000	109.856 Df=4 Sig=0.000
<5years vs.>5 years			-	216.728 Df=1 Sig=0.000	63.090 Df=4 Sig=0.000	135.348 Df=4 Sig=0.000	113.850 Df=1 Sig=0.000
Curlength<5 vs. >5 years				-	23.704 Df=4 Sig=0.000	36.978 Df=1 Sig=0.000	17.333 1 Sig=0.000
All training					-	181.421 Df=4 Sig=0.000	183.541 Df=4 Sig=0.000

---

Involved y/n	-	359.374
		Df=1
		0.000
Made alert y/n		-

---

**Appendix T Table showing number of times each factor was presented throughout the whole vignette study**

Factor	Level 1 Number of presentations (% of total)	Level 2 Number of presentations (% of total)	Level 3 Number of presentations (% of total)	Level 4 Number of presentations (% of total)	Level 5 Number of presentations (% of total)
Organisational support	Supportive 532 (50%)	Unsupportive 523 (50%)			
Reaction to whistleblowing	Listened to 515 (49%)	Dismissed 540 (51%)			
Reason for accessing services	Learning Disability (LD) 205 (19%)	Mental Health 220 (21%)	Older 227 (22%)	Physical disability (PD) 222 (21%)	LD & PD 181 (17%)
Psychology of victim	Negative 543 (51%)	Positive 512 (49%)			
Nature of abuse	Psychological 271 (26%)	Physical 273 (26%)	Financial 233 (22%)	Neglect 278 (26%)	
Severity of abuse	Mild 359 (34%)	Moderate 351 (33%)	Severe 346 (33%)		
Perpetrator past behaviour	Behaved in this way before 512 (49%)	First time 543 (51%)			
Victim perception of perpetrator	Don't like colleague 352 (33%)	Disclosed colleague hurt them 357 (34%)	Get on well with colleague 346 (33%)		
Information sharing	Asked not to tell	Agreed can share info			

	519 (49%)	536 (51%)	
Your relationship with perpetrator	Good friends with 343 (32.5%)	Never been friendly 369 (35%)	Know they haven't had much training 343 (32.5%)

## Appendix U Factorial survey regression models pre removing outliers.

Confidence; multiple regression model for “confidence” dependent variable, pre removing 1 outlier.

	B	Std. Error	Beta
<b>Step 1</b>			
Trxlength	.325	.094	.536***
CurLength <5 vs. >5 years	.302	.106	.096**
<5 vs. >5 years	-1.107	.253	-.349***
Involved Dichotomy yes/no	.513	.104	.171***
All Training	-.503	.166	-.370**
<b>Step 2</b>			
Trxlength	.345	.091	.570***
CurLength <5 vs. >5 years	.335	.103	.107***
<5 vs. >5 years	-1.176	.246	-.370***
Involved Dichotomy yes/no	.478	.101	.159***
All Training	-.538	.161	-.396***
Don't like colleague vs. get on well	.616	.200	.195**
rtime	-.359	.185	-.121
r1cult	-.567	.340	-.191
Financial vs. Psyc	.192	.126	.053
LD vs. Older	.100	.136	.027
Hasn't had any training vs. Never been friendly	-.136	.106	-.043
rinfosh	.279	.185	.094
Dictomtomous version of trait	.260	.186	.087
r2past	-.405	.345	-.136
Severity of abuse	.438	.081	.241***
LD and Phys dis vs. Older	.258	.141	.065
Phys vs. Psyc	.311	.134	.092*
MH services vs. Older	.012	.134	.003
Good friends vs. Never been friendly	-.488	.345	-.154
Coll hurt them vs. get on well	.664	.196	.211***
Neglect vs. Psyc	.389	.121	.115***
Phys Dis vs. Older	.111	.134	.030
difficulty rating adjusted to start at 1	.196	.163	.269
<b>Step 3</b>			

Trxlength	.358	.091	.591***
CurLength <5 vs. >5 years	.315	.102	.100**
<5 vs. >5 years	-1.213	.246	-.382***
Involved Dichotomy yes/no	.477	.100	.159***
All Training	-.554	.161	-.407***
Don't like colleague vs. get on well	.423	.107	.134***
Severity of abuse	.363	.053	.200***
Coll hurt them vs. get on well	.478	.107	.152***
Neglect vs. Psyc	.255	.099	.076**

Note:  $R^2 = .052$  for Step 1.  $R^2$  change was .084 for Step 2, and -.017 for Step 3.

\* $p < 0.05$  \*\* $p < 0.01$  \*\*\* $p < 0.001$

**Recognition; multiple regression model for “recognition” dependent variable, pre removing 8 outliers.**

	B	Std. Error	Beta
<b>Step 1</b>			
conf3	.329	.043	.199***
r2past	-.075	.177	-.015
Support	.924	.485	.268
LD vs. Older	.181	.193	.029
MH services vs. Older	.103	.190	.017
Phys Dis vs. Older	-.006	.190	-.001
LD and Phys dis vs. Older	.237	.201	.036
Dictomtomous version of trait	-.329	.266	-.067
Phys vs. Psyc	.705	.191	.125***
Financial vs. Psyc	.527	.180	.089**
Neglect vs. Psyc	.335	.173	.060
Severity of abuse	1.171	.117	.388***
rtime	.133	.264	.027
Don't like colleague vs. get on well	.065	.287	.012
Coll hurt them vs. get on well	.688	.282	.132*
rinfosh	-.526	.265	-.107*
Good friends vs. Never been friendly	.654	.492	.124
Hasn't had any training vs. Never been friendly	-.149	.151	-.028



difficulty rating adjusted to start at 1	-473	.233	-.393*
<b>Step 2</b>			
conf3	.343	.043	.208***
Support	.364	.131	.105**
Phys vs. Psyc	.798	.173	.142***
Financial vs. Psyc	.520	.180	.087**
Neglect vs. Psyc	.346	.172	.062*
Severity of abuse	1.257	.079	.417***
Coll hurt them vs. get on well	.771	.134	.148***
rinfosh	-.256	.131	-.052
difficulty rating adjusted to start at 1	-.218	.048	-.181***
<b>Step 3</b>			
conf3	.343	.043	.207***
Support	.299	.127	.087*
Phys vs. Psyc	.802	.173	.143***
Financial vs. Psyc	.502	.180	.084**
Neglect vs. Psyc	.322	.172	.058
Severity of abuse	1.264	.079	.419***
Coll hurt them vs. get on well	.779	.134	.150***
difficulty rating adjusted to start at 1	-.188	.046	-.156***
<b>Step 4</b>			
conf3	.351	.043	.212***
Support	.299	.127	.087*
Phys vs. Psyc	.639	.150	.114***
Financial vs. Psyc	.339	.158	.057*
Severity of abuse	1.256	.079	.417***
Coll hurt them vs. get on well	.773	.134	.148***
difficulty rating adjusted to start at 1	-.188	.046	-.156***

Note:  $R^2 = .352$  for Step 1.  $R^2$  change was  $-.008$  for Step 2,  $-.002$  for Step 3 and  $-.002$  in Step 4.

\* $p < 0.05$  \*\* $p < 0.01$  \*\*\* $p < 0.001$

**Reporting: multiple regression model for “reporting” dependent variable, pre removing 22 outliers.**

	B	Std Error	Beta
Step 1			
Support	.310	.128	.083*
adjrat3 scores +2 so starts from 1	.797	.023	.737***
Good friends vs. Never been friendly	.389	.150	.068**
difficulty rating adjusted to start at 1	-.191	.051	-.146***

Note:  $R^2 = .587$ .

\* $p < 0.05$  \*\* $p < 0.01$  \*\*\* $p < 0.001$

## Appendix V Factorial survey categorical data chi-square contingency tables, and odds ratio calculations.

Odds ration calculations were carried out using the methodology described in Field (2009). The data from the contingency table below will be used as an example.

First, the odds of documenting when the participant had not previously been involved in safeguarding were calculated:

$$= \frac{\text{number not involved who documented}}{\text{number not involved who didn't document}}$$
$$= 45/25$$
$$= 1.8$$

Then the odds of documenting when the participant had previously been involved in in safeguarding were calculated:

$$= \frac{\text{number involved who documented}}{\text{number involved who didn't document}}$$
$$= 77/17$$
$$= 4.529$$

The odds ratio is the odds of documenting with past involvement, divided by the odds of documenting without past involvement:

$$= 4.529/1.8$$
$$= 2.51$$

Therefore the odds of documenting were 2.51 times higher when the person had past involvement with safeguarding.

The contingency table is shown below.

Involved Dichotomy yes/no \* Document vs. no action Crosstabulation

		Document vs. no action		Total
		0	1	
Involved Dichotomy yes/no 0	Count	25	45	70
	Expected Count	17.9	52.1	70.0
	% within Involved Dichotomy yes/no	35.7%	64.3%	100.0%
	% within Document vs. no action	59.5%	36.9%	42.7%
	% of Total	15.2%	27.4%	42.7%
	Std. Residual	1.7	-1.0	
1	Count	17	77	94
	Expected Count	24.1	69.9	94.0
	% within Involved Dichotomy yes/no	18.1%	81.9%	100.0%
	% within Document vs. no action	40.5%	63.1%	57.3%
	% of Total	10.4%	47.0%	57.3%
	Std. Residual	-1.4	.8	
Total	Count	42	122	164
	Expected Count	42.0	122.0	164.0
	% within Involved Dichotomy yes/no	25.6%	74.4%	100.0%
	% within Document vs. no action	100.0%	100.0%	100.0%
	% of Total	25.6%	74.4%	100.0%

## **Appendix W      What does safeguarding adults training look like in Cornwall?**

Safeguarding Adults training is provided in three main levels in Cornwall; basic introduction, which is delivered via e-learning; Human rights workshop, combining Safeguarding Adults, Mental Capacity Act and Equality and Diversity training under a Human Rights framework at level 2; and Safeguarding Adults, a manager and team leader perspective at level 3.

Human Rights training:

Appropriate for

Front line staff, including managers and team leaders of health, social care and other related services, either paid or on a voluntary basis.

Background

This workshop consists of a single day which aims to support staff who need to be aware of issues around Safeguarding Adults, the Mental Capacity Act and Equality and Diversity. It is designed to refresh and promote the practical application of the core one training, using case studies and group work to support this.

The workshop is delivered on a multi-agency basis in various locations throughout Cornwall.

Pre Workshop Requirements

Delegates must have attended or completed (via e-learning) core one training in all three areas; Equality and Diversity, Mental Capacity Act and Safeguarding Adults.

Aims

To enable application of:

Safeguarding Adults

The Mental Capacity Act

Principles of Equality and Diversity

So that the Human Rights of each individual are protected and promoted effectively.

To underpin the relevant dimensions of the NHS KSF and social care standards at level 3.

Objectives

By the end of the workshop delegates will have

Evidenced their relevant knowledge and areas where further learning is required

Used case studies and examples to:

Practice identifying safeguarding, mental capacity and equality and diversity issues

Describe and demonstrate ways in which appropriate policies, procedures and tools for challenge can be used effectively.

Recognised and listed ways in which they will apply the learning in the workplace through the construction of a SMART action plan.

Manager and team leader training:

Appropriate for

Managers and Team Leaders of health, social care and other related services, whose responsibilities include receiving an initial "Alert" from a Service User, Carer, paid or voluntary worker.

Background

This course consists of two workshops and delegates will need to attend both sessions. The first one-day session aims to assist Managers/Team Leaders to be aware of their role in Safeguarding Adults work and enable them to be confident in making referrals according to Cornwall and Isles of Scilly Multi-Agency Safeguarding Adults Policy. It will also contain a session on action planning which will encourage delegates to consider how they will change practice, policies and procedures within their organisations with regard to safeguarding adults from abuse and neglect.

The second part of the course is a ½ day workshop, which follows approximately one month after the first, and provides an opportunity for delegates to feedback on the outcomes from their action plans, using SWOT analysis and Change Theories to support their plans.

The course is delivered on a CASC/ACS Multi-agency basis throughout Cornwall and the Isles of Scilly.

Pre-course requirements

Delegates must have attended Human Rights for One and All Workshop - incorporating Safeguarding Adults Core 2 prior to enrolling on this course (with the exception of the Devon and Cornwall Police who will have attended equivalent in-house training).

Learning Outcomes

Having completed Safeguarding Adults – A Manager/Team Leader Perspective and received the necessary organisational support and reinforcement, all delegates will have gained knowledge in the following areas:

Day 1 (full day)

Vision and Values in health and social care – managers as leaders.

Safeguarding Adults – the wider picture - including registration with ISA and the expansions to the vocabulary associated with financial abuse i.e. mass marketing fraud, scam mail, bogus lotteries/competitions, clairvoyant scammers, parasitic abuse etc.

Thresholds – poor practice or abuse?

What can we learn from past experience?

The Safeguarding Adults process – a Manager/Team Leader's role.

Transferring learning into practice.

Action Planning, looking at internal Safeguarding policies, practices and procedures.

Day 2 (half day)

Feedback from delegates on the outcomes from their action plans.

Use of SWOT Analysis and Change Theory – supporting plans for change within organisations.

(Cornwall Council 2010)

## **Appendix X      Publications**

Two journal publications are shown on the following pages. Permission to reproduce them has been granted by Emerald Group Publishing Ltd.

Pike, L., Indge, R., Leverton, C., Ford, D. & Gilbert, T. (2010) 'Bridging the gap between learning and practice: from where we were to where we are now'. *The Journal of Adult Protection*, 12 (2). pp 28-38.

Pike, L., Gilbert, T., Leverton, C., Indge, R. & Ford, D. (2011) 'Training, knowledge and confidence in safeguarding adults: results from a postal survey of the health and social care sector in a single county'. *The Journal of Adult Protection*, 13 (5). pp 259-274.



*X.1. Publication: Bridging the gap between learning and practice: from where we were to where we are now (2010)*

**Lindsey Pike, Roger Indge, Corinne Leverton, Deirdre Ford and Tony Gilbert**

**Key words:**

Training transfer, learning transfer, safeguarding vulnerable adults, human rights, learning, training

**Abstract**

Cornwall has implemented significant changes to the way that it delivers its safeguarding adults training. This paper outlines the benefits of combining safeguarding adults, the Mental Capacity Act 2005 (HM Government, 2005a) and equality and diversity training within a human rights framework. It examines the notion of learning transfer and considers how the design and delivery of training can improve the transfer of learning into practice. Finally, it highlights the importance of a receptive workplace culture to promote effective learning transfer.

**Introduction**

The impact of Steven Hoskin's murder in 2006 was felt by his family, his community, and the professionals who worked with him, as well as wider society (Rickell, 2007). Steven was eligible for services due to his learning disability. His engagement with services was sporadic for a variety of reasons. Between mid-2005 and July 2006, a multitude of agencies missed numerous opportunities to intervene, using safeguarding

adults procedures, to prevent the people he thought of as friends from subjecting him to the abuse that led to his murder. As time went on, he had contact with agencies more frequently, but a safeguarding alert was never raised. Following his murder, a Serious Case Review sought to establish whether lessons could be learned from the circumstances of the case, to inform and improve practice (Flynn, 2007).

Although training was not explicitly criticised in the report, the circumstances surrounding Steven's death caused staff working in the Learning, Training and Development Unit of Cornwall Council's Adult Care and Support (formerly Adult Social Care) to reflect on the purpose and use of training. Missed opportunities for intervention described in the Serious Case Review confirmed a lack of awareness of Steven's status as a vulnerable adult and the risk of abuse to which he was exposed (Flynn, 2007). The implication was that some staff, even after receiving safeguarding training, were not able to consistently transfer their learning into practice. Given this awareness, the Learning, Training and Development Unit (LTDU) has reviewed its safeguarding adults training strategy. This paper will consider the progress that has taken place in terms of content, ideology and delivery of the training.

The LTDU provides a number of levels of safeguarding adults training to multi-agency staff groups. This includes staff from the statutory, independent and voluntary sectors, as well as bespoke training to single agency groups, which have included befriending schemes, community pharmacists, members of the clergy, Alcoholics Anonymous and personal assistants working with people who receive direct payments.

## **Introductory (core one) training**

It has been recognised that face-to-face introductory safeguarding adults training cannot realistically be delivered to all staff and volunteers who need it in the health and social care sector in Cornwall (estimated to be 20–30,000 people), due to resource constraints. For this reason, it was decided to invest in e-learning to cover the basics of safeguarding, as well as other topics, to replace face-to-face sessions. E-learning has recognised advantages, including flexible learning, reducing the need for travel, allowing delegates to work at their own pace when it is convenient to them, economy of scale, and the ability to reach a wide audience (Clark, 2007). Many studies have found that e-learning is as effective at increasing knowledge and skills in terms of learning as face-to-face training (Strother, 2002). A meta-analysis of the effectiveness of e-learning versus classroom-based teaching found that levels of both learning of declarative knowledge (facts) and satisfaction with the course were, overall, equal between the two. Various factors including the level of learner control, the opportunity to practice and whether feedback is received, as well as the duration of course, have been found to influence the amount learnt through e-learning (Sitzmann et al, 2006).

Disadvantages have also been recognised; these include lack of face-to-face contact (which inhibits clarification of points through discussion), lack of computer literacy, equity of access, and questions over academic honesty. However, we believe that in order to address the need for basic information (recognising, responding to, and reporting abuse) to be conveyed to the whole sector, e-learning is a more efficient and effective method than face-to-face training, and a survey we have conducted of people

who have completed our safeguarding package shows that it is generally well received (Learning, Training and Development Unit, 2009). In the nine months that safeguarding e-learning has been available in Cornwall (to December 2009), almost 3,000 people have completed it; in comparison, between April 2006 and March 2009, records show that 516 people attended face-to-face training at core one level. Nevertheless, we recognise that e-learning creates a very different learning environment compared to face-to-face training, which is why it will only be used at an introductory level.

### **Core two training**

As mentioned above, although e-learning is useful due to its economies of scale, it also has its disadvantages. As well as increasing knowledge and skills, higher level safeguarding training has the potential to challenge values, beliefs and practice; discussion and debate may be needed to successfully do this. Furthermore, experiential learning is purported to be the optimum way to encourage reflective practice in training, and this involves learners exploring their own experiences, beliefs and values (Horwath & Morrison, 1999). Due to its interactive nature, face-to-face training is more likely to facilitate reflection than e-learning.

Because of this, we have continued to provide our next level of learning as a face-to-face course, which is delivered on a multi-agency basis. Horwath and Morrison (1999) suggest that in a climate of continuous change, the trainer's role in motivating learners is vital, making e-learning an unsuitable option for this level of training. Furthermore, they point out that a skilled trainer can tailor sessions to challenge and engage delegates with a range of learning methods, and remind them of the need to

generalise their learning back to their workplace. In terms of the multi-agency nature of the training, in a review of best evidence on interprofessional learning, Hammick et al (2007) found that it is generally well received by participants and can enable collaborative working. Comments on feedback forms in Cornwall have indicated that the multi-agency aspect of the training is important, as it gives staff an insight into the problems faced by other agencies and encourages better multi-agency working.

When working in social care, synthesising all the relevant guidance, codes of practice and legislation can be challenging. Anecdotal evidence from past training showed that some staff thought that safeguarding guidance, the Mental Capacity Act 2005 (HM Government, 2005a) and equality and diversity legislation (eg. Disability Discrimination Amendment Act 2005 (HM Government, 2005b)) contradict rather than support each other; others found it difficult to see the links and commonalities between them. Research into how to make training effective has shown that for learning to be transferred, it must be perceived as relevant and useful (Alliger et al, 1997; Baldwin & Ford, 1988; Liebermann & Hoffmann, 2008; Axtell et al, 1997). Furthermore, the transfer distance should be small: this means that training should be as similar to situations in the workplace as possible to make it easier to apply in practice (Holton & Baldwin, 2003). When working, staff need to be able to integrate the principles of the Mental Capacity Act 2005 and equality and diversity, as well as being aware of safeguarding issues at all times. Therefore to decrease the transfer distance and make training more relevant to social care staff, these three issues have been integrated in our training.

Consequently, while the format (face-to-face training) and target group (all staff and volunteers who have contact with vulnerable adults) remain the same for this level of training, one of the major changes that has been made is the decision to combine three core multi-agency training strands of safeguarding adults, mental capacity, and equality and diversity under the umbrella of human rights, to create a 'Human rights' workshop. Attendance at the workshop necessitates a basic knowledge of the three components, which can be obtained through the aforementioned e-learning or in-house face-to-face training in the county. The workshop acts as a gateway to managers' workshops and other specialist safeguarding adults training, and has a strong emphasis on the practical application of its content.

We believe that by presenting all three subjects as integral and complementary elements to upholding all individuals' human rights, safeguarding work is more likely to be incorporated into everyday care and support activities, rather than being seen as a freestanding and separate entity. Referring to safeguarding, the Commission for Social Care Inspection (now the Care Quality Commission) stated that 'the evidence suggests that arrangements work best where the whole system is underpinned by shared objectives and a common human rights value system' (Commission for Social Care Inspection, 2008, p78). This is the principle that underpins our new training.

The events surrounding Steven Hoskin's murder illustrate the importance of viewing the elements of human rights, mental capacity and equality and diversity as key pillars of safeguarding adults. Failure to respect Steven's human rights were evident, not least regarding his rights to private and family life (HM Government, 1998, Article 8) and freedom from torture and inhuman or degrading treatment (Article 3). Numerous

incidents are detailed where a safeguarding adults alert could reasonably have been made. Steven's mental capacity was not considered when he decided to refuse care services and neither was a risk assessment undertaken, despite earlier concerns regarding coercion. Steven's situation also raises questions about equality and diversity; would his disclosure to staff at the minor injury unit that he had been assaulted (Flynn, 2007) have been reported to the police if he had not had a learning disability? Questions also arise over whether, as a vulnerable adult, Steven was able to access the services he needed (Flynn, 2007).

Cases of abuse, some examples of which are identified below, frequently involve issues surrounding mental capacity, equality and diversity, human rights violations as well as safeguarding; this is why it is appropriate to put a strong emphasis on the connections and commonalities between them. Boxes 1, 2 and 3 (below) describe examples of systemic abuse, followed by a table that demonstrates how interchangeable and related the issues are. Table 1 (overleaf) demonstrates the poor practice that occurred around mental capacity, equality and diversity and human rights that contributed to the safeguarding issues in each of the three examples.

**Box 1**

An investigation into Sutton and Merton Primary Care Trust was initiated in early 2006 after the Healthcare Commission was informed of a number of serious incidents, including alleged physical and sexual abuse. The investigation found that the model of care was largely based on the convenience of the service providers rather than needs of individuals. Although some good practice was found, the provision of activities was poor and privacy and dignity of individuals was sometimes compromised. The incidents of physical and sexual abuse were confirmed (Healthcare Commission, 2007).

Box 2

A leaked council report in 1994 revealed that for 10 years, people living in a long-stay institution in Buckinghamshire for people with a learning disability (Longcare) had been abused physically, sexually and emotionally. The main perpetrator was company owner, Gordon Rowe, although his wife and management team were also implicated (Pring, 2005a).

Box 3

In 2005, services for people with a learning disability provided by Cornwall Partnership NHS Trust were investigated by the Healthcare Commission and the Commission for Social Care Inspection. This followed serious concerns about the standards of care and treatment provided to people living in long stay assessment and treatment centres and supported living settings. Widespread institutional abuse, which resulted in the physical and emotional abuse of individuals, was uncovered (Commission for Healthcare Audit and Inspection, 2006).

Table 1

	Safeguarding issues	Mental capacity issues	Equality and diversity issues	Human rights issues (article in brackets)
Sutton and Merton PCT	Institutional abuse Physical abuse (restraint) Sexual abuse Discrimination	Staff had poor communication skills Lack of advocacy	Discrimination leading to poor access to health care Limited activities Unsuitable housing	Degrading treatment (3)
Longcare	Institutional abuse Physical abuse Sexual abuse Psychological abuse Neglect Discrimination	No choice to leave Couples split up	Humiliation of residents Police thought that 'residents were not reliable witnesses' due to their learning disability (discrimination)	Torture and degrading treatment (2) Liberty (5) Private and family life (8) Discrimination (14)



Cornwall Partnership NHS Trust	Psychological abuse Physical abuse Institutional abuse Discrimination	No choice regarding where to live, who with, or who provides care- 'looked after'	Discrimination on the grounds of disability	Liberty (5) Degrading treatment (3) Discrimination (14) Private and family life (8)
<i>(Healthcare Commission, 2007; Pring, 2005a; Pring, 2005b; Commission for Healthcare Audit and Inspection, 2006)</i>				

The Association of Directors of Adult Social Services (2005) define safeguarding adults as

‘all work which enables an adult who is or may be eligible for community care services to retain independence, wellbeing and choice and to access their human right to live a life that is free from abuse and neglect’.

Our new approach reflects this holistic definition. Our intention is to facilitate safeguarding by advocating the principles of equality and diversity and the Mental Capacity Act 2005, while promoting each individual’s human rights. This will also contribute to the outcomes of choice and control outlined in *Our Health, Our Care, Our Say* (Department of Health, 2006) and reinforced by *Putting People First* (Ministers et al, 2007).

### **Learning transfer**

As well as reviewing the structure and format of training, we have implemented a two-year Knowledge Transfer Partnership (KTP) project, examining how we can make our training programmes most effective. The project aims ultimately to reduce the frequency and severity of adult abuse in Cornwall through more effective training,

while reducing the extensive impact of abuse on individuals, families and communities, and collating a sound evidence base on the subject. A KTP is a collaboration between an organisation (in this case, Cornwall Council Adult Care and Support's LTDU) a university (The University of Plymouth) and an associate (the project manager) who addresses a problem using evidence-based methods. In our case, the problem concerned the fact that over 2,000 health and social care staff and volunteers in Cornwall were being trained annually in safeguarding without any evidence of whether attending had an effect on practice.

Learning transfer (putting learning into practice) is an important subject but one that may not receive appropriate attention when designing training programmes. Certainly in Cornwall, trainers' roles have historically centred on the design and delivery of training, with responsibility for implementation viewed as the remit of delegates and their managers. Across all sectors, it is estimated that only 10% of learning transfers into job performance (Holton & Baldwin, 2003). Similarly, low rates of learning transfer have been found in studies of social care training without intervention (Clarke, 2001; 2002).

Kirkpatrick's (1967) four-level model, although dated, is still frequently used as a method of evaluating the effectiveness of training. The model outlines four stages of evaluation as follows.

1. Reaction – how did delegates feel at the end of the day?
2. Learning – what has been learnt?
3. Behaviour – how has that learning been translated into action?
4. Results – how has training helped to achieve these?

The higher levels of evaluation (behaviour and organisational goals) are generally recognised to be more difficult and costly to measure, as long-term follow-up is needed to capture what are often subtle changes. Consequently, most training is evaluated at the reaction level, using 'end of day' questionnaires. This is despite an increasing body of evidence that suggests that reaction to training has a variable correlation with its long-term effect (Alliger et al, 1997; Dysvik & Kuvaas, 2008). Horwath and Morrison (1999), discussing evaluating training in social care, argue that in the higher levels of evaluation, control of variables decreases. Therefore, by the time organisational goals are considered, the quality of training may have had a relatively small impact compared to other factors such as quality of supervision, staff turnover, organisational change and work culture (Horwath & Morrison, 1999). This implies that even if the training content and delivery are perfectly suited to the subject, a plethora of other factors will also influence the level of transfer of learning into practice.

Looking at training as a single event is, therefore, unlikely to enhance effectiveness. Instead, it should be viewed as a long-term process with the aim of changing and improving practice, incorporating three stages of preparation, training, and implementation (Zenger et al, 2005).

Research literature has provided useful findings with regard to improving the effectiveness of training. One study tracked a multidisciplinary group of mental health staff who attended an eight-day training programme on psychosocial interventions. An experimental group had half a day of a 'relapse prevention' module incorporated into the programme, which aimed to raise awareness about barriers to generalising

learning into practice through problem-solving, goal-setting and simulating problem-solving skills (Milne et al, 2002). The study found that the group receiving the extra module had a higher rate of transfer at follow up. Consequently, in Cornwall, we have included a short presentation on training transfer in our human rights workshop in an attempt to raise awareness of the issue: due to the limited time we have available (a single day), this is brief but we are monitoring the impact.

We have also incorporated learning logs and action plans into the workshop to encourage delegates to consider what definite knowledge and actions they can transfer back to their workplace. The learning logs include a question about what the delegate will do differently as a result of this learning. This is advocated by Balen and Masson (2008), who looked at child protection education and suggested using child abuse inquiry reports to reflect on mistakes that were made, and how those mistakes could be avoided in learners' own practice. A similar approach is used in our training, with real case studies broken down and used as discussion points for the actions that could have been taken at each stage to prevent the actual outcome. Learning points are then recorded by delegates.

Persuasive evidence also exists for the use of action plans. Locke and Latham (2002) detailed evidence of the effectiveness of goal-setting in training in their summary of 35 years of empirical research. They argue that setting a specific and difficult goal has consistently been found to be more effective in terms of performance than urging people to do their best, although there are many things that moderate the success of goal-setting. In their meta-analysis, Burke and Hutchins (2007) found that formulating learning goals has a strong to moderate relationship with training transfer. The

learning logs and action plans also act as a tool to encourage supervisor support, which has been widely recognised as important in learning transfer (Lim & Johnson, 2002; Burke & Hutchins, 2007; Clarke, 2002). Learners are encouraged to discuss learning logs and action plans in their next supervision, to inform their manager of their learning and devise a plan to implement it in practice with the manager's support.

In response to the transfer literature, we are phasing in a three-stage approach to the human rights training. The elements will comprise:

- a preparation stage: a mandatory application process where prospective delegates, together with their managers, consider why they need to attend the training, what they think they will gain, areas of practice that it will improve, possible barriers to transferring their learning and ways to ensure implementation of learning
- training stage: incorporating learning logs, action plans, awareness of the difficulties in transferring learning, and activities relevant to the delegates attending
- implementation stage: support to implement learning provided in training will also be highlighted in managers' workshops, to raise awareness of the importance of workplace culture in applying new learning.

There have been challenges in implementing this system as it involves time (which is often in short supply) being spent by delegates and their managers on preparing and consolidating training. Perceptions persist of training being primarily an exercise in meeting regulatory requirements. Accordingly, training and transferring learning can be a low priority. Changing this perception of training from an event to a process-based model will take time, but it should ultimately contribute to the development of learning organisations; organisations typified by having 'strong cultures that promote openness, creativity, and experimentation among members ... [which] encourage members to acquire, process and share information, nurture innovation and provide

the freedom to try new things, to risk failure and to learn from mistakes' (Social Care Institute for Excellence, 2004)

### **Systemic factors**

The realisation that training transfer depends heavily on systemic factors in the work environment is an important one. Even where training is relevant, engaging, informative, interactive and motivational, delegates returning to a workplace where there is no support to implement it will probably find implementation a challenge. Individuals on their own cannot make training effective; they need to work within systems that promote the transfer of their learning to practice through effective workforce development structures. Systems theory has recently been used to develop a multi-agency approach to safeguarding children case reviews, which states that:

'The cornerstone of a systems approach is that individuals are not totally free to choose between good and problematic practice. Instead the standard of performance is connected to features of people's tasks, tools, and operating environment.' (Fish et al, 2008)

This principle applies equally to safeguarding adults practice following training. Even if staff intend to transfer their learning to make improvements to practice in the workplace after training, workplace culture, constraints on time and resources, and attitudes to new practice may provide barriers to transfer.

Research that has examined factors that either facilitate or provide barriers to training transfer has found that managerial support, staff support, and a supportive work climate may be the most important factors in training transfer (Lim & Johnson, 2002; Stolee et al, 2009). This seems especially relevant to safeguarding where workplace culture has a huge impact on standards of care. Some parallels can be drawn with

whistleblowing, which has also been shown to be affected by workplace and staff culture. The problem is summed up succinctly by Calcraft (2007, p23) who states that:

‘... while adult protection policies and professional values require workers to raise concerns about abuse, the culture within a team or within an organisation may discourage speaking out.’

Calcraft (2007) details a number of inquiries and research findings highlighting the importance of support for people who whistleblow, and the influence of organisational culture on whistleblowing behaviour. Reports suggest that organisational factors, such as treatment of the whistleblower and reactions to attempts to raise concerns, deter even experienced staff (Bjørkelo et al, 2008; Jackson et al, 1997). Therefore, training is unlikely to do more than inform staff about what they should do, rather than assist them to overcome such workplace barriers. Considering whistleblowing as one potential outcome of training, practice resulting from training needs to interact with good management practice and a supportive work environment to enhance existing organisational culture; knowledgeable staff will not be able to tackle safeguarding issues armed with just training. Put simply:

‘Training alone is insufficient to ensuring knowledge transfer, competence and performance improvement’ (Stolee et al, 2009, p15).

Baby Peter was a 17-month-old boy who died in August 2007 due to physical injury and neglect, after having repeated contact with services (Haringey Local Safeguarding Children’s Board, 2009). In an analysis of the events leading up to his death, workplace culture was identified as one of the three aspects that should be considered when understanding the actions of an individual professional (Jones, 2009). The issue of training transfer can, therefore, be related to the much wider challenge of matching up the theoretical picture of alerting espoused in training, with the practical reality of

alerting on the frontline. For example, anecdotal evidence from frontline staff shows that identified good practice in the form of feedback to staff making alerts and adherence to procedures and specified timescales are not always realised. A challenge remains to ensure that frontline practice consistently meets the requirements and standards expressed in training.

### **Barriers to training transfer**

A number of barriers to transferring social care training to the workplace have been identified in the literature; these include heavy workloads, time pressures, lack of reinforcement of training, staff turnover, an absence of feedback on performance, and the perception of in-service training (Clarke, 2002; Stolee et al, 2009). More positively, supportive management has been found to overcome a number of these barriers (Stolee et al, 2009), again highlighting the importance of not viewing the effects of training as separate from practice.

Recognition of these findings by the LTDU has led to a greater awareness of the complexity of training transfer. It has also led to the acknowledgement that the LTDU on its own has relatively little control over the effectiveness of training, as so much depends on the workplace and learning culture. As a Learning Training and Development Unit, we can advocate the principles of learning organisations, such as undertaking learning needs analyses, providing supervision, relaying feedback from training in team meetings, encouraging an open culture for discussing best practice, and conceptualising training as a means to continually improve practice rather than a tick-box exercise (Social Care Institute for Excellence, 2004), but we can do little to



enforce them. However, commissioners of services clearly have a significant part to play in creating the expectation of learning cultures in organisations.

Our task now is to continue to focus on learning transfer, adopt the principles of learning organisations, and promote continuing professional development within the county. Cornwall has employed six whole time equivalent continuing professional development (CPD) workers, whose remit is to promote effective learning transfer for the whole health and social care sector in Cornwall in order to support these aspirations. Training has been identified as lacking in numerous Serious Case Reviews and inquiries (Aylett, 2008), but we need to move beyond the notion that problems can be addressed by training, to the thinking that problems can be addressed by supporting the implementation of training. Our human rights workshop is undergoing an in-depth evaluation to ascertain whether the three-stage model of training can be effective and how transfer can be enhanced, and in time we will implement the techniques used over a wider range of the training programmes delivered by the LTDU. Furthermore, we realise that safeguarding will never be effective if we give information about it to staff alone, so we are working on providing more safeguarding and human rights training to people who use our adult care and support services, by working in partnership with them.

## **Conclusion**

To make safeguarding adults training effective, it should not be viewed as an isolated subject but one that is married to the principles of equality and diversity and the Mental Capacity Act 2005, within a broader framework of human rights, in order to

enable a holistic view of care and support. To make any training event effective, evidence suggests that preparation and follow-up are necessary to ensure implementation of learning in practice. Finally, for the training process to be effective, it needs to be set within a learning culture that accepts, values and enables the principles advocated in training. We have made progress towards these three aspirations in Cornwall but there is still a lot of work to be done, and we would welcome comments and suggestions regarding the work we have begun.

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*X.2. Publication: Training, knowledge and confidence in safeguarding adults: results from a postal survey of the adult social care sector in a single county (2011)*

**Lindsey Pike, Tony Gilbert, Corinne Leverton, Deidre Ford & Roger Indge**

**Abstract:**

Following a Serious Case Review, Cornwall's Adult Protection Committee decided to obtain a baseline of knowledge of Safeguarding by staff working across the social care sector. Central to establishing this baseline was the role of training as it was apparent that despite a considerable outlay in money and human resources to support training abuse continued to occur. Moreover, the understanding of factors that contributed to the effectiveness or otherwise of training needed further work. In 2009, a survey of staff working in organisations across the social care sector was completed using a self-completing postal questionnaire.

The results identify a range of issues for managers and training professionals, which include the following. Professionals were identified as performing significantly better than managers on knowledge questions. Significant differences were observed in the knowledge of safeguarding by staff in different agencies. Training contributed to approximately 20% increase in the knowledge of safeguarding in the staff group as a whole. A ceiling effect was noted where around 33% of staff fail to answer the key knowledge question correctly despite training. However, possibly the most significant outcome of the survey was the role of confidence, taken here as self assessed



knowledge in safeguarding, which provided a significant link between knowledge and a person's willingness to act on that knowledge. Furthermore, staff scoring higher on 'confidence' were more likely to raise organisational and systems based issues when asked how safeguarding might be improved in contrast to those with lower scores who tended to only identify training.

**Key words: Safeguarding, training, knowledge, confidence**

## **INTRODUCTION AND BACKGROUND**

The following research was commissioned following a Serious Case Review into the murder of a man eligible for services due to his learning disability in Cornwall in 2006. One of the main findings from the Serious Case Review was that staff from a number of organisations in the authority had missed numerous opportunities to step in to potentially change the course of events that lead to his murder (Flynn, 2006). Although staff training was not highlighted as a failing, it was clear that staff involved in the case either lacked the knowledge to intervene, or were unable to put what they had learned in training into practice (see Pike et al, 2010). Following the review, Cornwall's Adult Protection Committee decided to obtain a baseline of knowledge of Safeguarding in Cornwall to measure future progress against. This was articulated as an action point from the SCR:

"To undertake an anonymous and representative sample survey of operational staff and managers across all APC[Adult Protection Committee] member agencies measuring people's knowledge of existing adult protection procedures, confidence in using these procedures and feedback in doing so."

(Cornwall Adult Protection Committee, 2007:6)

The overarching question concerned how to prevent occurrences of abuse in the future, and another priority was to work proactively to change the culture of organisations that enabled abuse to occur. Central to this aspiration was the role of training as it was apparent that despite a considerable outlay in money and human resources to support training, abuse had not been prevented. In addition, it was recognised that the understanding of factors that contributed to the effectiveness or otherwise of training needed to be developed, both within the local authority's training unit and the organisations that it provided training to. Nevertheless, it was clear to all concerned that a greater understanding of the baseline levels of knowledge of Safeguarding was required as a first stage in the process. Literature on the three key issues of knowledge, confidence and feedback in Safeguarding Adults is quite scant, but a brief overview is given below.

### **Knowledge**

Qualitative interviews have been used as the method of choice to investigate staff knowledge of issues surrounding Safeguarding in the UK (Taylor and Dodd, 2003; Parley, 2010; Furness, 2006). Taylor and Dodd (2003) explored staff knowledge and attitudes towards abuse and reporting procedure, in a bid to understand patterns of reporting abuse. 150 staff from health, social services, and the independent and voluntary sector participated by completing semi structured interviews. Topics covered included definitions of abuse, vulnerability, thresholds to reporting, reluctance to report, reporting procedure, and training. Physical and psychological abuse was

identified by most participants, while neglect was only mentioned by about half, and was not considered abuse by police. Regarding thresholds, 35% said they would only report abuse if they considered it “severe enough”, and 75% would only report if they had concrete evidence. A correlation was found between reporting abuse and understanding of abuse and correct reporting procedure. People with a recognised professional qualification, or who had attended training, were more knowledgeable.

Parley (2010) investigated staff views of vulnerability and abuse. She interviewed 20 staff from social services, the NHS, the private and independent sector and found a lack of clarity over what constitutes abuse, and little recognition of the connection between human rights and abuse. There was also an implicit level of tolerance of abuse, where behaviour that was disrespectful or contemptuous, or “roughly handling people” (pg 22) was overlooked. Sexual and physical abuse were generally thought to be “worse” than the other types, which were not identified as readily; abuse was also associated with intent to harm. The author found little difference in perspective between staff from different agencies; this was stated to be due to the fact that all staff had worked in health settings.

Furness (2006) interviewed 19 managers and 19 residents in older people’s care homes to find out their views around issues related to inspection, regulation, and ways to better protect older people from abuse. When defining abuse, physical abuse was mentioned most frequently by managers, followed by verbal, financial and psychological abuse. Sexual abuse was not mentioned, implying that the client group that staff work with can influence staff perceptions of risk of certain types of abuse. 90% of managers had witnessed abuse in their working lives. Perceptions of the

seriousness of abuse, prior experience of managing cases of abuse, confidence in approaching external agencies for advice, and knowledge and understanding of safeguarding policies and procedures were all found to affect the way that managers respond to and deal with abusive care staff.

All three studies used qualitative interviews to gather their data, and consequently were carried out on fairly small scale samples. To our knowledge, no survey data has been collected about the level of knowledge or views on the process of Safeguarding held by health and social care staff in the UK.

However, a recent systematic review claimed to be the first to examine health and social care professionals' knowledge, detection and reporting of elder abuse specifically (Cooper, Selwood and Livingston, 2009). The review covered 32 papers, including twenty-one surveys, nine analyses of elder abuse reports to statutory bodies, and two intervention studies. The majority (20) studies were from the USA, while 7 were from the UK. 6 UK studies used interviews to ask specific groups of staff (e.g. GPs, qualified nurses, community mental health trust staff, or medical students) about their knowledge, detection, and/ or reporting of elder abuse (Kitchen et al, 2002; McLaughlin and Lavery, 1999; McCreadie et al, 2000; McCreadie et al, 1998; Selwood et al, 2007; and Thompson-McCormick et al, 2009). The remaining UK study looked at the effect of face-to-face training versus printed material using a randomised controlled trial method and a validated measure (Richardson et al, 2002).

Regarding knowledge of staff, the review summarised that three studies, one representative, underestimated the prevalence of elder abuse, while 75% of US nurses

and physicians incorrectly believed that most abuse resulted in major injury. The summary around knowledge of abuse law and guidelines centred on US studies.

## **Confidence**

The training transfer literature, which explores the extent to which knowledge and skills developed during training are implemented when people return to the workplace, points out that knowledge does not necessarily translate into action (e.g. Alliger et al 1997, Smith et al 2006). Existing literature suggests that an additional factor, confidence, may be a necessary condition for knowledge to be translated into action.

The systematic literature review by Cooper et al (2009) identified lack of confidence as a barrier to reporting abuse. Five surveys in the US and Canada showed that professionals lacked confidence in their ability to identify abuse and reporting procedures. A meta-analysis of three US surveys using the Elder Abuse Questionnaire found that a significant proportion of health professionals would not report abuse unless they were certain that it had occurred.

Taylor and Dodd (2003) reported that attending training appeared to increase people's confidence to report abuse. The issue of confidence following training or other learning and development interventions has been explored in the literature, and appears to be an important outcome of training, as it implies a preparedness to act, as opposed to knowledge, which does not imply such action. Lawrence and Banerjee (2010) evaluated the work of a support team, which aimed to improve care in care

homes by working closely with the staff. They found that the intervention increased the confidence of staff, with participants reporting feeling more knowledgeable and skilled in their role, which boosted confidence and morale. Confidence to act may be vital in Safeguarding, which is an area that often relies on subjective judgements and can lead to negative repercussions for staff (Calcraft, 2007). It seems intuitive that staff who 'raise their head above the parapet' to whistleblow would only do so if they were confident that their actions were the right ones. Taylor et al (2008), reporting on the effect of negotiation training on performance, postulated that increased confidence and perceived success make training transfer more likely, and that level of confidence or perceived skill may "set the limit" to the potential success of a training programme in improving performance in the workplace (pg 139). Perceived confidence and intention to transfer learning to practice was also correlated with actual use of new skills, implying that confidence may be an important predictor of behaviour.

However, training alone is not sufficient to maintain high levels of confidence in newly learned skills. Killick and Allen (2005) reported on an evaluation of positive behaviour management training for staff at an adolescent inpatient unit. Levels of knowledge increased and were sustained at 12 month follow up. However, scores from an aggression questionnaire, which measured staff confidence in dealing with violent incidents, showed that staff confidence was significantly increased post training but this increase was not sustained over time. The authors discussed refresher training as an important way to maintain confidence levels post training, and additional factors such as supervisor support, opportunity to use skills, and other factors in the work

environment have been shown to facilitate the maintenance of skills over time (Burke and Hutchins, 2007).

Confidence has also been used as a method of measuring learning. In an evaluation of a university based peer mentoring programme, Terrion et al (2007) asked delegates to evaluate their confidence in each of the four core competencies of a training programme before and after attending training; confidence levels were significantly improved post training. This improvement was supported by more objective measurements namely the analysis of entries into a log book, but no explicit relationship was discussed between degree of use of learned skills and confidence levels.

## **Feedback**

The largest scale attempt to collate feedback on Safeguarding Adults in the UK came in the form of the Review of No Secrets (Department of Health, 2009). Launched in 2008, the consultation collated the views of 12,000 people and identified a number of issues to consider, including:

- Safeguarding must be built on empowerment (listening to the victim's voice),
- Better leadership is needed,
- The NHS has struggled to "own" safeguarding and is underdeveloped in the area,
- Improved information sharing is believed by the Police to be key to more effective Safeguarding,
- Most respondents supported the idea of Safeguarding legislation
- Terminology may need revising (e.g. "vulnerable adult")

Furthermore, national procedures were identified by most as being important, to alleviate problems with working over local authority boundaries. A preventative

approach was agreed by 97% as being necessary, and an outcomes based framework was also seen as being potentially useful. Many respondents wanted a document that outlines roles and responsibilities, details national training competencies and ensures that feedback from people using the service is collated to inform policy and practice. There were frequent references to the lack of knowledge about the effectiveness of safeguarding adults training. Very little is known on this topic; a review of the literature on elder abuse found just two intervention studies on the topic of safeguarding adults training, but found evidence that a group training course, and a video focussing on the management of elder abuse improved knowledge (Cooper et al 2009).

Cooper et al (2009) also summarised the evidence on elder abuse reporting to adult protective services in the USA. They found that there was no evidence that state-enforced initiatives such as mandatory reporting, mandatory training, or penalty fines for not reporting increased reporting of elder abuse.

## **METHODOLOGY:**

### **Aims and objectives**

The aim of the current survey was to obtain a baseline of different staff groups' understanding about safeguarding and how factors such as training, role and agency impacted on this understanding.

The objectives were to provide baseline data regarding the relationship between knowledge of safeguarding and the:



- individual's job role
- agency in which the person is based
- type and level of training undertaken by the individual
- individual's self-rated confidence in their knowledge of safeguarding
- individual making a safeguarding 'alert'

## **Design**

The decision to undertake a postal questionnaire was based on the fact that this provided the best way to quickly develop a baseline of activity and understanding across the sector. Consequentially the data collection tool had to be fairly simple to avoid problems in the interpretation of questions (Bowling, 2002). A postal distribution method was favoured over an electronic survey due to issues of access to the internet for many staff working in health and social care, and the moderately higher response rates reported with postal surveys (Beebe et al. 2007).

## **Sampling**

The sample frame (Bowling, 2002) for the project was developed from the data bases kept by the statutory agencies that were part of the Adult Protection Committee. Included in the first iteration of the sample frame were major health and social care organisations including the Primary Care Trust, Adult Social Care, Hospitals Trust, Ambulance Trust and Mental Health Trust, as well as the Private and Independent sector and Police. Most organisations included all departments/ divisions in the sample frame, but the Hospitals Trust requested only departments concerned with Adult Safeguarding be included. The second stage of development saw data regarding

the total number of staff working in the agency, and numbers of staff who worked in individual workplaces obtained from contacts in the statutory organisations and estimated for the Private and Independent sector.

Once the sample frame had been developed and checked for omissions and duplications, random groups of staff were selected by location using a method of random number generation until one fifth of the total population were sampled. Private and Independent care providers were selected from Adult Social Care's commissioning list. No staff numbers were available for private and independent providers, so an estimate of 20 staff per location was used. The same random number generation process was followed for all agencies.

### **Questionnaire development**

The design frame for the questionnaire (Oppenheim 1992) was developed by synthesising the views of a panel of professionals with issues raised in previous research (Taylor and Dodd, 2003, Furness, 2006, Parley, 2010). This provided four sections: personal information [role, organisation and training attended]; contact and knowledge of vulnerable adult; understanding of safeguarding; knowledge of safeguarding process [knowledge and suggestions for improvement]. It was decided that a mixture of closed and open questions would provide an idea of both the scale and detail of knowledge around Safeguarding. The question topics and rationale for including them are outlined in appendix 1.

The questionnaire was piloted on a group of staff attending Safeguarding Adults training to ensure clarity of questions, before being sent out in January 2009.

## **Process**

In statutory organisations, staff were informed that they might be asked to participate in a survey via the organisations' newsletter. This was not possible in the independent and private sector. Batches of questionnaires were sent out to organisations with cover letters explaining the purpose of the study, information sheets for each participant and a freepost return envelope. Each pack also included a consent form with an optional prize draw entry. No restrictions were set around who should respond to the survey; a cover letter requested that the survey be distributed to all staff who worked at that location. The researcher's name and contact details were clearly stated in case any issues arose with completion of the survey. The survey had a return date approximately three weeks after it was posted after which a reminder was sent. Because of the difficulties of relaying a message to the Private and Independent sector as a whole, no follow-up letter was sent out to them.

Response rates per agency are detailed below:

	Sent	Received	%
Ambulance	92	33	36
Police	287	69	24
PCT	223	49	22
Mental Health Trust	193	30	16
Hospital Trust	250	47	19
Adult Social Care	322	85	26
Private & Independent	2400	334	14
Totals:	3767	647	17%

The overall response rate of 17% is generally disappointing and lower than we hoped for. If we split this between sectors there is a 23% response rate for the statutory sector and 14% for the Private and Independent sectors. However, as noted above we believe that this study is unique in attempting to survey the sector within a county and it raises questions about how to maintain databases that enable the effective dissemination and collection of information.

### **Data collection and analysis**

Questionnaires were returned via Freepost. Numerical data was transferred first to an Excel spreadsheet and checked for accuracy. Open questions were transferred verbatim and illegible text responses marked for discussion by the researcher and colleagues. Initial descriptive analysis was performed using Excel. Data was later

transferred to SPSS and a coding frame developed to manage qualitative elements numerically.

### **Ethical issues**

Ethical approval was obtained from Cornwall Council Research Ethics committee and permission to extend the study to NHS was obtained via the Safeguarding Adults Board through the individual trusts and agencies represented.

### **FINDINGS**

The following section explores the relationship between the core dependent variable – the respondent's knowledge of abuse and a number of independent variables. Non-parametric tests were preferred as the data was ordinal. Scores on the dependent variable 'Knowledge of Safeguarding' were obtained by asking respondents to identify what type of issues the Safeguarding Adults agenda addressed, from a list of 11 possibilities. These included the 7 categories from 'No Secrets'. There was no limit on the number of categories people could use as they were assumed to have answered the question correctly if they identified all 7 categories regardless of how many additional categories they included. They were considered to have answered the question incorrectly if they omitted any 'No Secrets' categories. The rationale was that identifying a closely related issue as constituting abuse was not a problem but missing a key category was. The additional categories were: family disputes, homelessness, incorrect benefits, and substance misuse. A 'Don't know' option was also included.

## Knowledge of Safeguarding and Job role

This compares respondents performance related to their knowledge of safeguarding with the primary role they perform within the agency i.e. a professional might also be a manager, in this case they are classified managers. There are some interesting differences in the analysis [table 1]. For example, as a percentage, professionals perform better than managers but the best performance is given by support workers. The relatively high percentages by ancillary and administration staff are probably an artefact of low numbers in the category.

**Table 1: Number of people who identified all the correct categories of abuse by job role:**

Knowledge of safeguarding	Manager	Professional	Senior support worker	Support worker	Ancillary	Admin	Other	Total
Correct	58 [45%]	41 [58%]	66 [52%]	157[69%]	18 [67%]	20 [50%]	14[56%]	374
incorrect	70 [55%]	30 [42%]	61 [48%]	72 [31%]	9 [33%]	20 [50%]	11[44%]	273
Total	128	71	127	229	27	40	25	647

Re-coding responses to enable comparison of the performance of respondents whose primary role was as either a manager or a professional using the Wilcoxon matched-pairs test identified a significant difference:  $z = -2.753$ ; significance [2-tailed]  $p < 0.006$ . This implies that professionals in non-managerial roles have a greater understanding of issues related to abuse than managers which resonates somewhat with Taylor and

Dodd's (2003) findings although, managers might be expected to perform equally with professionals.

### Knowledge of Safeguarding and Agency

We then considered whether there was a relationship between knowledge and the agency in which the worker was based.

**Table 2: Number of people who identified all the correct categories of abuse by agency:**

Knowledge of safe-guarding	NHS MH		Ind &Vol	PCT	POLICE	Hosp Trust	Amb	Total
	Trust	ASC					Service	
Correct	13[43%]	55 [65%]	228[68%]	25 [51%]	20 [29%]	26 [55%]	7 [21%]	374
Incorrect	17[57%]	30 [35%]	106 [32%]	24 [49%]	49 [71%]	21 [45%]	26 [79%]	237
Total	30	85	334	49	69	47	33	647

\* Mental Health [MH] NHS Trust; Adult Social Care [ASC]; Independent & Voluntary Sector [Ind & Vol], Primary Care Trust [PCT]; Acute [AC] NHS Trust; ambulance service [Amb Service]

Table 2 suggests that there are marked differences in the knowledge of safeguarding based on agency. Some of this difference might be explained by the different perspectives workers within these agencies have about their positions within the safeguarding process. At the same time, the differences within health services appear to contradict findings by Parley (2010). Re-coding all health staff into a single category

provided an overall score of 45% correct which when compared with adult social care using Wilcoxon matched-pairs test identified a significant difference;  $z = -21.965$ ; significance [2-tailed]  $p < 0.000$ .

### Knowledge of Safeguarding and Training

This following section explores the relationship between respondent's knowledge of safeguarding and whether they had completed training. Of those who had undertaken training the majority had completed Core One training<sup>1</sup> provided by ASC. However, a number had undertaken ASC's Core Two training<sup>2</sup> as well as Core One or Provider Manger Training. Another group had undertaken a range of different forms of training related to safeguarding but not provided by ASC.

**Table 3: Number of people who identified all the correct categories of abuse by Core One Training:**

Knowledge of safeguarding	Core One Training	No training	Total
Correct	164 [66%]	210 [53%]	374
Incorrect	84 [34%]	189 [47%]	273
Total	248	399	647

Overall performance by respondents who had undertaken Core One Training demonstrated was similar to those who indicated they had undertaken training not provided by ASC at 66% correct. However, it is useful to note that 53% of those with no



training also gave correct answers, a difference of 13% between those providing a correct answer and having/not having training. A similar performance was achieved by those having undertaken Core Two training with 68% [81] giving the correct answer.

The gap between participants who achieve the ‘correct’ answers and those that do not suggests a ‘training effect’ or ‘training gain’ ranging from 13 – 19%. Re-coding all forms of safeguarding training into a single category enabled analysis of the overall effect of training on knowledge.

**Table 4: Number of people who identified all the correct categories of abuse by all types of Training:**

Knowledge of safeguarding	Training	No training	Total
Correct	98 [64%]	276 [45%]	374
Incorrect	119 [36%]	154 [55%]	273
Total	217	430	647

Respondents who had undertaken training in safeguarding performed well, 64% providing correct answers in contrast to the 45% achieved by people who had not had any training: Wilcoxon matched-pairs test:  $z = -7.533$ ; significance [2-tailed]  $p < 0.000$ . These results suggest floor and ceiling effects to the effectiveness of training and a ‘training effect’ of 19%. There is a range of ways, including media, through which people become sensitised to categories of abuse also; some of the options on the questionnaire were suggestive. What is more difficult to explain is the ceiling effect.

This suggests that despite training approximately one third of respondents provide an incorrect answer, namely they failed to identify one or more of the categories identified by 'No Secrets'.

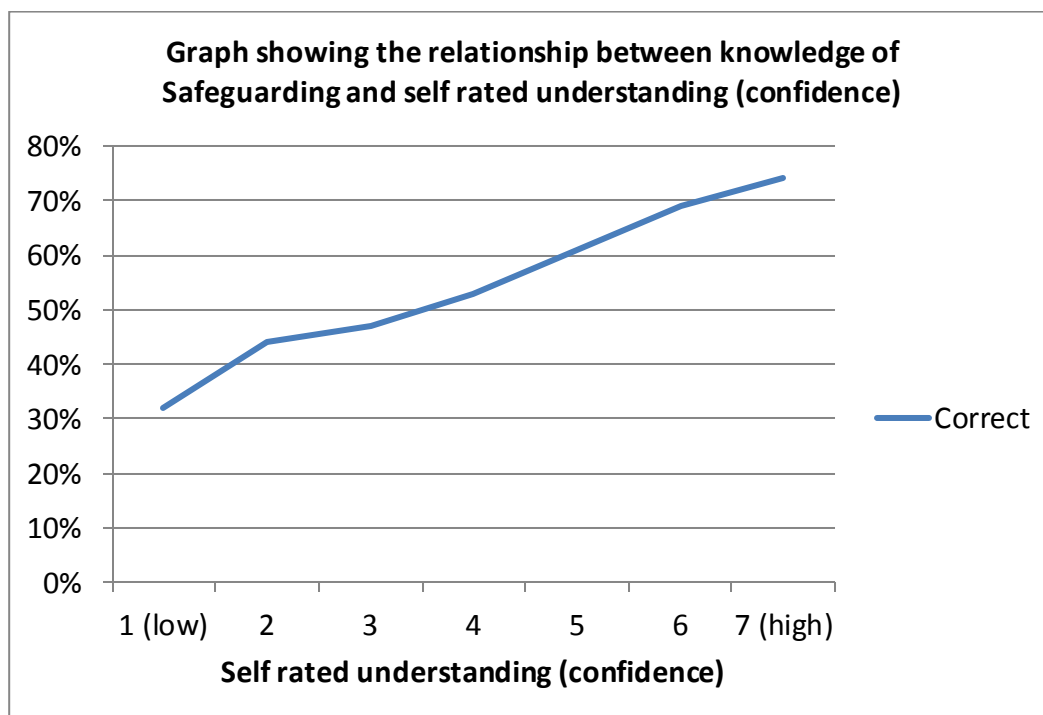
To explore this relationship further 'knowledge' was re-coded as follows: [1] incorrect answer, [2] one category of abuse omitted, [3] identified all categories plus one or more other categories, [4] identified all categories of abuse correctly. At the same time, training was re-coded to identify the highest level of training undertaken: 1 = no training; 2 = Core 1; 3 = Core 2; 4 = provider manager. Analysis of correlation provided evidence of a moderate correlation: Spearman  $\rho = 0.234$ ; significance [two-tailed]  $p < 0.000$ .

### **Knowledge of Safeguarding and Self-rated Understanding**

The next section explores the relationship between a person's actual performance and their self-rated knowledge of safeguarding which also stands as a proxy for confidence. The table below [table 6] explores the relationship between knowledge of categories of abuse and 'self rated' understanding [confidence] based on a scale of 1 – 7. The higher score represents a higher level of confidence by the respondent in their knowledge of safeguarding.

**Table 5: Number of people who identified all the correct categories of abuse by ‘Self Rated’ understanding.**

Knowledge of safeguarding	1(low)	2	3	4	5	6	7 (high)	(blank)	Total
Correct	10[32%]	24[44%]	39[47%]	60[53%]	85[61%]	85[69%]	67[74%]	2[18%]	374
Incorrect	21[68%]	31[56%]	44[53%]	53[47%]	54[39%]	38[31%]	23[26%]	9[82%]	273
Total	31	55	83	113	139	123	90	11	647



Visually the observed gradient of percentages suggests a relationship between knowledge and ‘self rated’ confidence. Respondents performing weakly on the factual test also indicate a lower level of confidence than participants who perform better on

the factual test whose performance is matched by higher levels of 'self rated' confidence. Re-coding of the variable 'knowledge' to the ordinal scale as above enabled analysis of correlation with 'self rated' understanding. This provided evidence of a moderate correlation: Spearman  $\rho = 0.264$ ; significance [two-tailed]  $p < 0.01$ . 'Self-rated understanding' was then compared with 'All training' [table 4.] and a moderate to strong correlation is identified: Spearman  $\rho = 0.531$ ; significance [two-tailed]  $p < 0.01$ .

Further exploration revealed a relationship between job role and confidence. Confidence ratings were grouped into three categories; 1-2 (low), 3,4,5 (moderate) and 6-7 (high). Of particular interest were the confidence ratings of managers versus professionals; managers were more likely to rate their understanding of safeguarding as high (69%) than professionals (15%), and most professionals(71%) rated their understanding as moderate, compared to only 30% of managers. These ratings do not tally with our (admittedly crude) measures of knowledge; one possible explanation may be that managers feel pressured to 'know it all', whereas professionals feel more able to express uncertainty in their knowledge. Another possible explanation is that professionals are likely to be involved more fully in complex cases, and therefore their knowledge of the process and related issues needs to be greater than managers whose responsibilities may end with making an alert.

Evidence of correlations between, 'self-rated understanding' and 'knowledge', and 'self-rated understanding' and 'training', suggest that a person's own evaluation [confidence] plus evidence of training is an important factor when assessing knowledge levels. This conclusion has to be treated with caution due to the strength of

the correlation however; it does suggest possibilities for further investigation and the potential of developing a rapid assessment tool based on confidence and evidence of training.

### Knowledge of safeguarding and persons having made an ‘alert’

This section looks to identify those individuals who report having made an ‘alert’ in the past and how this compares to their knowledge of safeguarding.

**Table 6: Number of people who identified all the correct categories of abuse and who identified as having made a safeguarding alert.**

Knowledge of safeguarding	Made an ‘Alert’			Total
	No	Yes	(blank)	
Correct	278 [58%]	94 [61%]	2 [14%]	374
incorrect	202 [42%]	59 [39%]	12 [86%]	273
Total	480 [74%]	153 [24%]	14 [2%]	647

One key question for the study is whether knowledge of safeguarding influences people’s ability or willingness to make ‘alerts’. In total, 24% of the sample reported having made an alert of which 15% provided the correct answers to the knowledge question. Analysis for correlation did not meet 95% significance level. However, analysis of ‘self rated’ understanding and ‘making an alert’ provided a moderate correlation: Spearman  $\rho = 0.224$ ; significance [2-tailed]  $p < 0.01$ . This suggests

knowledge alone is not a sufficient condition for a person to make an alert. However, ‘confidence’ in that knowledge may be a necessary condition. This relationship between training and confidence suggests two factors that may influence whether a person will make an alert. At this point, it would be useful to develop a correlation matrix to map relationships:

**Table 7: Correlation matrix showing significant correlations between ‘knowledge of safeguarding’, ‘self-rated understanding’, ‘training’, ‘Job role’, ‘Agency’, ‘identifies a vulnerable adult’ and ‘made an alert’.**

Variable	Knowledge of safe-guarding	Self rated Under standing	Training	Job role	Agency	Identifies Vulnerable Adult	Made alert
Knowledge of Safe-guarding		.264**	.234**	.083*			
Self rated under standing			.531**		-.094*		.224**
Training				-.160**	0.148**		.282**
Job role					0.312**	0.159**	
Agency						0.069*	-.251**

\* Spearman *rho* correlation significant at 0.05 [1-tailed]

\*\* Spearman *rho* correlation significant at 0.01 [1-tailed]

The matrix identifies a number of weak to moderate correlations between key variables. Central to the findings are the significant relationships between 'knowledge', 'training' and 'self-rated understanding' [confidence]. Equally striking is the lack of a relationship between 'knowledge' and 'identifying a vulnerable adult'. In addition, 'knowledge' itself appears to have little impact on whether individuals have made an alert, whereas 'self-rated understanding' [confidence] demonstrates a moderate relationship with 'making an alert'. Both 'knowledge' and 'confidence' demonstrate relationships with 'training'. The centrality of training to confidence and the way these together contribute to influencing whether a person makes an alert or not is worth further investigation. These findings also resonate with those of Taylor et al (2008) and Burke and Hutchins (2007).

### **Suggestions regarding how the Safeguarding Adults process could be improved versus self rated understanding (confidence)**

The questionnaire also included a number of free text questions. One of these questions was, "How do you think the current Safeguarding Adults process could be improved?" 392 respondents (61%) made a comment. Comments were then coded into 20 initial categories, which were then condensed to 8, including those who left the question blank. Categorisation of comments by LP was checked by TG, and differences in opinion resolved through discussion. Comments containing more than one category of response were coded to the dominant category. Categories were cross-tabulated with 'self rated' understanding (confidence), to determine whether respondents with a

higher level of confidence have different opinions regarding how safeguarding could be improved, compared to those with a lower confidence level.

The following table shows the percentage of respondents within each level of confidence who mentioned the stated category of way of improving the safeguarding process.

**Table 8. Compressed codes: How could safeguarding be improved?**

Confidence	Think it is ok	Training	Communication	Process	Resources	Focus on Person	Staff Support	DK/ Blank	Total (n)
1(low)	0[0%]	10[32%]	0[0%]	0[0%]	0[0%]	0[0%]	0[0%]	21[68%]	<b>31</b>
2	0[0%]	20[36%]	0[0%]	0[0%]	3[5%]	0[0%]	0[0%]	32[58%]	<b>55</b>
3	1[1%]	32[39%]	3[4%]	2[2%]	6[7%]	0[0%]	1[1%]	37[45%]	<b>82</b>
4	0[0%]	38[33%]	8[7%]	2[2%]	5[4%]	0[0%]	0[0%]	61[54%]	<b>114</b>
5	3[2%]	37[27%]	11[8%]	10[7%]	2[1%]	1[1%]	5[4%]	70[50%]	<b>139</b>
6	6[5%]	26[21%]	6[5%]	14[11%]	15[12%]	2[2%]	2[2%]	52[42%]	<b>123</b>
7(high)	4[4%]	11[12%]	7[8%]	8[9%]	6[7%]	0[0%]	3[3%]	51[57%]	<b>90</b>
<b>Total</b>	<b>14[2%]</b>	<b>174[27%]</b>	<b>35[6%]</b>	<b>36[6%]</b>	<b>37[6%]</b>	<b>3[0%]</b>	<b>11[2%]</b>	<b>324[51%]</b>	<b>634</b>

The table shows that respondents with lower confidence in their understanding of safeguarding were more likely to answer, 'increase or improve training'. Alternatively, they answered, 'don't know' or left the question blank. Respondents with higher confidence were more likely to mention issues such as communication, process-based



issues, resources, the need to focus on the person and the need to support staff through the safeguarding process. Numbers of respondents mentioning training as a way to improve the safeguarding process generally decreased with increased confidence. However, the high percentage (approximately 50%) of respondents who answered 'don't know', or left the question blank, means these findings need further investigation.

## **LIMITATIONS**

The discussion of the findings has to take account of the limitations of the study. First, a postal questionnaire is a useful instrument for obtaining information quickly from a large group of people. However, while it can help identify associations between variables it cannot explore subtle relationships or causality. Such tasks have to be left for future studies. In addition, the response rate was lower than hoped for and may have been affected by organisations' internal communication processes; response bias may have also affected the results, in that it is possible that the staff who responded are not representative of the staff population as a whole.

The biggest limitation is the measure of knowledge used. An answer to a multiple choice question on the issues addressed by the Safeguarding Agenda provides somewhat shaky ground from which to assess practitioners' knowledge of Safeguarding Adults, and the rationale behind a correct answer (all "No Secrets" categories of abuse must be included, other categories can also be included) means that respondents who ticked all the boxes were classed as correct. This is a simplistic

measure, limited by the method used. Furthermore, much literature indicates that knowledge does not necessarily result in changed practice (e.g. Smith et al 2006), and behaviour relating to Safeguarding was not measured here. Further research is needed to determine appropriate ways to assess staff knowledge and practice around Safeguarding Adults. A vignette based approach may provide one way to address this problem (Richardson et al, 2003).

## **DISCUSSION**

Despite the limitations outlined above, the survey included responses from 647 individuals working across adult health and social care and as far as we can identify is the largest study of its kind to-date.

The first issue that requires further exploration is the observed differences between managers and professionals. Potentially this provides a worrying situation, as managers are central to the safeguarding process where subordinate staff including professionals will need to refer to a manager to activate procedures. The comparatively high number of senior support staff and support staff who answer correctly is encouraging but again the discrepancy between the knowledge level of this group and managers suggests a weakness in the system. One possible explanation is that managers rely on obtaining more in depth advice and guidance on safeguarding issues from professionals.

There are also clear differences in the knowledge of safeguarding by agency, some of which may be explained differences in role and perspective. For example the primary

concern for police is whether a crime has been committed, whereas Safeguarding concerns a whole array of abuses of Human Rights which may not be classified criminal. Parley (2010) also points out that the language used in adult protection such as physical, verbal and sexual abuse are not always associated with “lay terms such as assault and battery, harassment and bullying, theft, rape etc” (pg 14). Therefore a lack of police knowledge around Safeguarding may be due to crimes not being recognised as crimes, and consequently not being reported. Our finding that NHS based services’ knowledge of Safeguarding was poorer supports the No Secrets Review report, which concluded that leadership around safeguarding has been poor in the organisation, and the concept has yet to be owned by the NHS (DH, 2009).

Finally, the level of knowledge in the adult social care and independent and voluntary sectors while significantly higher than health falls below 70%. Taking the fact that the main focus of both sectors is working with people at risk then a situation where between a quarter and a third of the workforce is unable to provide the correct answer to a relatively simple question about safeguarding must give rise for concern; the fact that they are the biggest providers of care compounds this.

This latter point leads nicely into a discussion of the effectiveness or otherwise of training. Earlier we noted results that suggested two important factors related to training. First, was the apparent floor and ceiling effects where just under half of respondents demonstrate a baseline knowledge of safeguarding without any training. In contrast, a little over one third of respondents who had received training failed to demonstrate this baseline knowledge. This second factor, based on these results, suggests that training has an effect on improving knowledge of a little less than 20%.

Together these two factors provide evidence of both the efficiency of current training and of a section of approximately one third of the workforce who need targeting in a different way. At first glance, an increase of 20% may appear a poor return for the effort and expense of training such a large and disparate workforce. However, it is difficult to gauge the influence of training on the general culture of care involving people at risk and the 'trickle down' effect of training on the knowledge of those who have not attended any training event. Killick and Allen (2005) found no difference between groups who had and had not received relevant training in knowledge of strategies for behavioural management. The authors suggest that information sharing between colleagues may have led to this effect. Smith et al (2006) also highlight the importance of informal learning.

In many ways, one might assume that a sense of common humanity identified in recruitment processes and reinforced by good-enough practices might lead to a reasonable person achieving the correct answers to the baseline question. Nevertheless, baseline knowledge of safeguarding was identified in approximately two thirds of staff.

Where issues around training become very interesting is when we introduce into the discussion the notion of 'self-assessed' knowledge, which we have taken as a proxy for 'confidence'. Here the findings support a relationship between 'knowledge of safeguarding' and 'training', and 'knowledge of safeguarding' and 'confidence'. However, we did not observe a correlation between 'knowledge of safeguarding' and 'making an alert'. Rather, the relationship with 'making an alert' lies in the correlation with 'training' and 'confidence'. This resonates with the findings of those involved in

research concerned with training transfer who point to the existence of a range of factors that influence behavioural change in the workplace (Taylor et al 2008; Burke and Hutchins 2007). This needs further exploration as it would be reassuring to suggest that real benefit of training lies not only in the knowledge people have of safeguarding but their confidence in that knowledge. However, an alternative explanation is that those people who request to attend training are more confident in their knowledge of Safeguarding as a group, although the findings of Killick and Allen (2005) would dispute this. In addition, the apparent importance of 'self assessed' knowledge and evidence of training could provide a useful tool to assess the culture of safeguarding within an organisation. This suggestion is reinforced when the moderate correlations between 'training', 'confidence' and 'having made an alert' are taken into consideration. This might be developed by linking it with Taylor and Dodd's (2003) findings of correlation between reporting abuse, understanding of abuse and knowledge of correct reporting procedure.

The validity of 'confidence' as a measure of understanding of issues in Safeguarding Adults is supported by the findings from the free text question on how the process could be improved. This found that people with higher levels of confidence were more likely to raise issues of process, resources, staff support, focussing on the person and communication as ways to improve the process, compared to those with a lower confidence, of whom the majority either suggested training, or wrote that they didn't know. Distilling the problems encountered when providing an effective safeguarding process down to a need for training is both simplistic and unrealistic, and it is telling

that people with lower confidence in their knowledge of safeguarding, on the whole, did not identify any other suggestions.

The perception that more or better training/ awareness/ understanding/ education/information can improve the process and the fact that it was the most frequently mentioned point (27% of responses) is both interesting and concerning. Clarke (2010) outlined the tendency in Adult Social Care as a sector to assume that training will fix all problems, and the fact that unfortunately this assumption is based on very little evidence. The findings outlined here support Clarke's ideas, in that half of the people who gave an answer other than "don't know" believed training was important. Horwath and Morrison (1999) point out that it is vital to see training in the context of other factors that influence effectiveness; these factors include clear goals, processes, support and supervision, positive learning climate, appropriate working environment, leadership, resources, policies, standards, user involvement and adequate staffing. A wide array of evidence suggests that without consideration of the systemic factors that affect the use of training in the workplace and training transfer, training is unlikely to be effective (e.g. Burke and Hutchins, 2007). Consideration of training transfer does not appear to have infiltrated thinking in adult social care to date; but the perception that 'training (alone) will fix it' must be challenged. Intervention studies concerning Safeguarding training are few and far between, and although some show that training results in increased knowledge, no clear link between training and behaviour change has been shown (Cooper et al, 2009). Further research is needed to clarify the mechanism by which training affects performance in Safeguarding.

## CONCLUSIONS

To our knowledge, this is the first major multiagency UK survey of its kind. One challenge in its execution was the lack of easily accessible information about the private and independent sector, which meant that sampling this group was a challenge; a coordinated database of care providers would make research in this area easier in the future.

Although a postal questionnaire is a blunt instrument with which to look at the issue of knowledge of, confidence in and feedback about the Safeguarding Adults process, some interesting relationships have been uncovered. It would be worthwhile to have a closer look at the factors that affect staff confidence in Safeguarding Adults skills in future research, in order to aim to build relevant systems into the workplace. The complexity of the adult social care sector means it is unlikely that one set of optimum conditions will be revealed; instead it may be more a case of asking which circumstances lead to improved performance, for whom, and how (i.e. Pawson et al, 2004).

### Notes:

<sup>1</sup> Core One training encompasses a basic introduction to Safeguarding, covering what abuse is, how to recognise, report and record it, and may take the form of a half day face to face session or e-learning

<sup>2</sup> Before April 2009, Core 2 training consisted of a half day course which aimed to examine the belief systems that influence practice, identify the context in which adult safeguarding takes place, including the legal perspective and develop an awareness of good practice in order to reduce risks. Post April 2009, this course was replaced by the Human Rights workshop, outcomes of which include being able to explain the relationship between Human Rights, Safeguarding Adults, the Mental Capacity Act and Equality and Diversity, use the principles of the Mental Capacity Act and the strands of Equality and Diversity legislation to prevent safeguarding issues occurring/ escalating and make a Safeguarding Adults Alert and know what timescales/feedback should be expected when responding.

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## Appendix 1

Organisation	Questionnaires were sent out in stages to different organisations. Information was recorded in order to find out the learning needs of particular organisations/ sectors.
Job title	Answers to this free text question were grouped into categories, (Manager, Professional, Senior Support Staff, Support Staff, Ancillary, Administrative, and Other) in order to see if any particular group of staff had learning needs around Safeguarding.
Degree of contact with vulnerable adults	This was included to find out if staff who had more contact with vulnerable adults had better knowledge of Safeguarding
Definition of vulnerable adult	To determine learning need around the definition of vulnerable adult; without awareness of the definition of vulnerability, Safeguarding procedures cannot be followed.
Issues addressed by Safeguarding	This encompasses the topic of "what is abuse" covered in previous studies

agenda	
Who to report to	This question aimed to identify knowledge about reporting procedures
Made an alert	This question was included to help determine the representativeness of respondents (i.e. do only people who have made alerts respond to questionnaires about Safeguarding) and to find out whether there is a correlation between making alerts and other questions, e.g. knowledge about Safeguarding or satisfaction with the process.
Self rated understanding of safeguarding	To determine general levels of perceived understanding, compare with demonstrated knowledge on the survey, and correlate with other questions, e.g. regarding training- a rating scale.
Satisfaction with process	To record perceptions of the process in Cornwall currently, and correlate answers with other questions- a rating scale.
Importance of knowledge of Safeguarding	To gauge how much of a priority Safeguarding is over the agencies and job roles- rating scale.
How could the process be improved	To obtain feedback on the effectiveness of the process and areas for improvement- a free text question.
Training attended	To determine the representativeness of the sample and correlate with other questions to determine effect of training on knowledge and alerting.
Ability to put training into practice	Questioning whether, after attending training, respondents had been able to put it into practice, and inviting comments on the subject
Lead agency	Questioned whether participants know who the lead agency for Safeguarding is in Cornwall.