Bridging the gap between learning and practice: from where we were to where we are now

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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.

key words
Training transfer, learning transfer, safeguarding vulnerable adults, human rights, learning, training

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 (e.g. 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 (below) and 3 (overleaf) 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.

The Association of Directors of Adult Social Services (2005) define safeguarding adults as ‘all work which enables an adult who is

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**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).

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**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 Poor practice

<table>
<thead>
<tr>
<th>Safeguarding issues</th>
<th>Mental capacity issues</th>
<th>Equality and diversity issues</th>
<th>Human rights issues (Article in brackets)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sutton and Merton PCT</td>
<td>Institutional abuse Physical abuse (restraint) Sexual abuse Discrimination</td>
<td>Staff had poor communication skills Lack of advocacy</td>
<td>Discrimination leading to poor access to health care Limited activities Unsuitable housing</td>
</tr>
<tr>
<td>Longcare Institutional abuse Physical abuse Sexual abuse Psychological abuse Neglect Discrimination</td>
<td>No choice to leave Couples split up</td>
<td>Humiliation of residents Police thought that ‘residents were not reliable witnesses’ due to their learning disability (discrimination)</td>
<td>Torture and degrading treatment (3) Liberty (5) Private and family life (8) Discrimination (14)</td>
</tr>
<tr>
<td>Cornwall Partnership NHS Trust Psychological abuse Physical abuse Institutional abuse Discrimination</td>
<td>No choice regarding where to live, who with, or who provides care – ‘looked after’</td>
<td>Discrimination on the grounds of disability</td>
<td>Liberty (5) Degrading treatment (3) Discrimination (14) Private and family life (8)</td>
</tr>
</tbody>
</table>

(Healthcare Commission, 2007; Pring, 2005a; Pring, 2005b; Commission for Healthcare Audit and Inspection, 2006)

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
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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 though 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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