THE TRAINING GAP: A HIDDEN INJUSTICE IN DEMENTIA CARE AND HOW TO FIX IT

England Edition

LEEDS BECKETT UNIVERSITY

Alzheimer's Society
It will take a society to beat dementia

IFF Research

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We would also like to thank staff and people who draw on care at the two case study sites featured in this report, who gave freely of their time and resources to enable the research to happen.

Finally, we would like to thank the steering group members, comprising academics and social care provider representatives, who ensured that the research reflected the evidence, concerns and priorities of the sector.

The following organisations (or individuals within these organisations) gave freely of their time in contributing to this report:

Hallmark Care Homes
Anglian Care
Southern Healthcare
Home Instead
The University of Kent
IFF Research

FOREWORD

THE LIVED EXPERIENCE INVOLVEMENT GROUP

As individuals who draw on care, or have done, including people living with dementia and unpaid carers, we signed up to provide lived experience stakeholder oversight to this project[a] because we were interested in dementia training. Based on our collective experience we had some awareness that dementia training across the social care workforce is variable and can very often be limited. Some of us assumed that staff delivering care to us and our loved ones had already received the right training. We all agreed that it is fair and right that staff who deliver dementia care should have had the appropriate training. After all, you wouldn't expect to have heart surgery from a surgeon who only had an awareness of how the heart works, who had never had specific training about the heart, or who wasn't extremely confident in doing so. We, like everyone else, expected the social care workforce to have the right training to care for people with dementia, even though experience tells us this isn't always the case.

Participating in this research provided an opportunity to explore and understand what was actually happening with dementia training for staff in social care, and why there exists so much variation. We were interested to see what might help with working towards better training, such as in-depth dementia training rather than short dementia awareness sessions. It has been clear to us that dementia care requires understanding that goes beyond basic dementia awareness and the findings of this project underline the scale of the gap and the importance of strengthening dementia training standards. Involvement in this project has given us a better picture of the scale and detail of the training gap and, with this information, it has helped us look again at our own care experiences. Some of us are at a point of transition, seeking new care providers, and asking directly about the training staff receive is at the forefront of our mind when making this incredibly important life choice. Some of us have been prompted to ask questions of our existing care providers when we would maybe not have raised questions before. Others have had the opportunity to reflect experiences which we now see in a different light. The project has given us more confidence to ask about training and to understand what should be in place for good dementia care.

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a All members of the Lived Experience Involvement Group for this research are existing members of the Lived Experience Involvement Panel for the Centre for Dementia Research at Leeds Beckett University

As a result of the findings of this report, we hope that the decision-makers and providers know how important it is to make sure that staff are trained more extensively than just awareness training. This is necessary for the provision of high-quality care. We were also interested, but maybe not surprised, to find out that training on how to work with and support families and relatives of people with dementia was often overlooked. We know first-hand how important it is to have these skills, particularly when staff are coming into someone's home, an incredibly personal and sensitive space. The shortfall in dementia training identified in this report needs wider recognition. People who draw on care, and those who may do so in the future, should have access to clear information about the type and level of training offered to staff. This enables individuals and families to ask questions and make informed decisions when choosing professional care.

FOREWORD

OONAGH SMYTH CBE

CEO, SKILLS FOR CARE

Strengthening our social care workforce to support people with dementia to live their lives well is one the most fundamental ways we can support the 826,000 people living with dementia in England right now, as well as those who may be diagnosed in the future.

We know that many people who live with dementia will, at some point in their lives, draw on some form of social care support. So, it's incredibly important that people working across social care are supported with the right training to deliver care that is not only safe but enhances people's wellbeing and quality of life.

Leeds Beckett University and Alzheimer's Society has examined what training is being provided to the social care workforce, and how this training aligns to the known benchmark standards for training.

Unfortunately, indicators from this research suggest the training being delivered isn't always dementia specific or at the right level to support our care workers to confidently deliver care for people with dementia. Additionally, it is often not delivered in ways that we know to be more effective for promoting learning.

This report highlights the need to do more to ensure that the social care workforce is appropriately equipped to deliver the quality of person-centred care that people living with dementia deserve. As Baroness Casey has recognised, everyone agrees dementia is becoming more prevalent, but we have not seen an equivalent response to this seismic challenge. The adult social care workforce is central to meeting that challenge. It's welcome that the Government plans to introduce a new dementia leadership role for Health and Social Care, and now everyone in a position to enact change should take account of these recommendations and enable providers to offer their direct care staff the right training to confidently deliver high-quality person-centred care.

ACCESSIBLE SUMMARY

WHAT IS THIS REPORT ABOUT?

This report provides a sector specific overview of dementia training for the social care workforce from the perspective of social care providers and recipients of training. It proposes a series of tangible and practical evidence informed recommendations, with costs, to facilitate the delivery of best practice dementia training for the social care workforce.

WHO SHOULD READ THIS REPORT?

This report is aimed at:

- Care home and domiciliary care providers, training leads and care staff
- Advisory bodies and regulators
- Commissioners, policy makers, and national government
- Researchers in dementia social care
- Dementia charities and campaign organisations
- People affected by dementia

WHAT DOES THE REPORT INCLUDE?

Findings from a national audit of providers, a survey of direct care staff and case studies in two social care providers. It also includes costed policy recommendations for commissioners, government, regulators and providers. Separate reports for Wales and Northern Ireland are available.

WHO TOOK PART?

Responses were received from 53 social care providers in England, reporting on 119 training packages. The survey was completed by 184 care staff. Two social care case study sites included staff and people living with or supporting someone with dementia who accessed the service. The project was guided by a steering group comprising of providers and academics, and a lay advisory group of people affected by dementia.

FINDINGS AND RECOMMENDATIONS

This report highlights the need to transform the way in which dementia training for the social care workforce is delivered and received. Despite some progress, this new research suggests that the training that staff currently receive is unlikely to be sufficient to equip the dementia care workforce to deliver high-quality person-centred care.

Focusing on the content of training, we found that over half of the training that is being accessed by the social care workforce covers the topic of dementia awareness only. Additionally, in our audit of care providers, only 39% of available dementia training was designed to deliver the knowledge and skills needed by social care staff who have regular contact with people living with dementia.

Our audit also showed that the way in which training was delivered fell short of best practice. Training is heavily reliant on e-learning, too short to have sufficient impact for learning and is often not evidence based.

From the survey of social care staff, we found that only 55% of staff were receiving dementia specific training; the recommended approach in terms of delivery and duration of training to deliver the knowledge and skills required for social care staff with regular contact with people with dementia (Tier 2 of the Dementia Training Standards Framework). Compared to the care provider audit, where 84% of training packages offered

were described as dementia specific, the staff survey result is much lower showing a contrast between what training is offered by care providers to what training care staff are actually accessing.

A much higher proportion of respondents to the staff survey (95%) reported getting any dementia training, including dementia content within generic training. However, this may be the only way many staff are receiving dementia content, particularly in the first critical year or so of working. Generic training with dementia content is unlikely to meet the threshold for best practice delivery outlined in this report (e.g. effective delivery method, such as sufficient time).

As a result, this report recommends a new legal requirement for all social care providers to ensure all direct care staff working in older adults' care - and direct care staff working with people living with dementia in other settings - undertake best practice dementia training. This should include both homecare and care home staff.

This should be given effect through CQC statutory guidance on dementia, with a requirement for staff to undertake best practice dementia training of at least eight hours, mapped to at least Tier 2 of the Dementia Training Standards Framework and with delivery meeting five key components of best practice training (evidence-informed training design; effective delivery method; inclusive digital learning; support and accessibility; and strong leadership to foster long-term impact of training). The guidance should make clear that this is necessary to comply with Regulation 18.

Government should consider how best to support providers to close the dementia training gap – and this report sets out the costs of ensuring all care staff undertake best practice training.

KEY DEFINITIONS FOR UNDERSTANDING THIS REPORT

BEST PRACTICE DEMENTIA TRAINING

Best practice dementia training should meet certain minimum requirements on content, delivery and duration. The content of best practice training should be aligned to the Dementia Training Standards Framework[2].

The Dementia Training Standards Framework describes 14 topics that are critical for the delivery of dementia care, with learning outcomes for each topic aligned to three training tiers based on a staff member's level of contact with people living with dementia: Tier 1 – awareness, which all health and social care staff should have; Tier 2 – knowledge and skills for staff with regular contact with people living with dementia, and Tier 3 – enhanced knowledge and skills for leadership in dementia care.

Training should also meet the five key components for best practice training as outlined in the report Because We're Human Too[3]. These components are: evidence informed training design, effective delivery method, digital inclusivity, support and accessibility, and strong leadership. It should include interactive in-person delivery, which may be online, provided there is an interactive element with a facilitator (rather than being self-directed e-learning only). Training should be of at least eight hours in total, with individual sessions lasting at least two hours[4].

DEMENTIA AWARENESS TRAINING

Dementia awareness is an introductory training topic designed to ensure that learners have a basic awareness of the needs of people with dementia and the people that support them. It is aimed at the entire health and care workforce, including staff who do not provide direct care to people living with dementia. Tier 1 of the Dementia Training Standards Framework covers the topic of dementia awareness only. Tier 2 (aimed at staff who have regular contact with people with dementia) can include awareness alongside other, more in-depth topics (e.g. communication behaviour and interaction, person-centred dementia care practice). The topic of dementia awareness can be delivered in dementia specific training, or as one topic in more general training for the workforce (such as induction).

DEMENTIA SPECIFIC TRAINING

Training targeted to the condition of dementia specifically, to promote knowledge and understanding of dementia and how to support people living with dementia, including family members and relatives. Dementia specific training is training that is primarily dementia focused and is not training that is more generalised with dementia content as one component (e.g. induction, Mental Capacity Act, general communication skills, etc). Dementia specific training can be delivered at any level of the Dementia Training Standards Framework, covering any of the 14 topics as standalone topics (including dementia awareness) or multiple topics. Dementia specific training is the recommended approach for the delivery of topics aligned to Tier 2 of the Dementia Training Standards Framework and it is more likely to align to best practice recommendations in terms of delivery and duration of training.

E-LEARNING

A form of training delivery that uses only digital-based content to be completed independently by learners, without the input of "live" interaction with facilitators or other learners.

WHY IS BEST PRACTICE DEMENTIA TRAINING IMPORTANT IN ENGLAND?

In England, there are 826,000 people living with dementia, a number projected to rise to around 1.2 million people by 2040. Dementia is an umbrella term for a range of progressive neurological diseases, including Alzheimer's disease, which is the most common cause of dementia. Alzheimer's disease is often characterised by its effect on memory function, although it often also affects things like language and vision. Other types of dementia also elicit a range of symptoms which impact on a person's ability to live in the same way as before a diagnosis.

Over time people living with dementia develop the need to draw on specialist support and care. This specialist support might take the form of care that is provided in one's own home (often referred to as home care or domiciliary care) or care that is provided away from home such as in residential homes or nursing homes (care homes). Best available modelling suggests that 70% of people living in care homes are living with diagnosed, or undiagnosed, dementia[5], and a high proportion of those receiving home care services have dementia too.

There is a wide variation in need across individuals and the many different types of dementia that people live with[6]. People living with dementia benefit from taking part in cognitively stimulating activity, both for their wellbeing and supporting their cognitive and functional abilities[7]. It is key for care staff to understand the person living with dementia's individual interests and plan activities which are engaging for them, including providing culturally appropriate care[6]. Dementia can profoundly affect communication and change throughout the course of the person's dementia journey, requiring care staff to adapt their communication to support them[6]. Care staff can sometimes struggle to understand complex behaviours, which can be expressed as unmet needs and may result in the inappropriate use of restrictions aggression[6]. Dementia is a complex condition, and care staff who directly provide support to people with dementia need the necessary knowledge and skills to deliver high quality support and care. No professional should be allowed to care for a person living with dementia without adequate training.

Despite this, there is currently no mandatory requirement for social care staff to undertake dementia specific training in England. The first National Dementia Strategy in 2009

cited the need for systemic dementia education[8]. This was furthered in the 2012 Prime Minister's challenge that made training a national priority, with a Health Education England mandate in 2014[9]. This mandate aimed to ensure that dementia was covered in all Higher Education pre-registration programmes by September 2015, that all NHS staff had access to at least dementia awareness training by 2018 and for staff working with people with dementia to have at least Tier 2 training.

Guidance and standards frameworks that encourage social care providers to ensure their staff receive appropriate dementia training have been developed. For example, dementia training for all staff is recommended in the NICE Guideline on dementia[10].

Additionally, the Dementia Training Standards Framework and the Care Certificate were introduced to set standards for knowledge and practice in the social care workforce. The adult social care workforce sector led strategy, developed by Skills for Care, published in July 2024 recommends that all care staff should undertake training mapped to the Dementia Training Standards Framework[11].

More broadly the Care Quality Commission's Regulation[18] requires providers to ensure staff "receive such appropriate support, training, professional development, as is necessary to enable them to carry out the duties they are employed to perform."[12] However, current data suggests that only 38% of social care staff in England are recorded as having undertaken condition specific dementia training[13].

The 'What Works study' was the most expansive study to date about dementia training, seeking to understand the features of impactful dementia delivery across England. This included a large-scale review of evaluated education and training programmes[14], a national audit of dementia education and training[15] and in-depth case studies within social care provider organisations[16]. The study found evidence indicating that many social care staff cannot access training that is evidence based or best practice. As a result, there remain well documented knowledge and skills gaps across the social care sector.

A range of evidence[11,17] has also consistently reported that a well-trained workforce provides better quality care. This evidence has been bought together and presented in the 2024 report from Alzheimer's Society 'Because We're Human Too: Why dementia training for care workers matters, and how to deliver it'[3].

Because We're Human Too sets out the significant benefits of dementia training to people living with dementia, care staff, care providers and the wider health and care system. It demonstrates that best practice dementia training can considerably improve people's quality of life, increase staff job satisfaction and lead to savings in the wider health and care system. Using existing evidence, the report drew together findings to define five key components of impactful dementia training: evidence-based training design, effective delivery method, inclusive digital learning, support and accessibility, strong leadership. This is set out in more detail below (page 25).

This new report uses these five key components to define best practice dementia training and uses the key components to assess training currently being provided to care staff across the social care sector. Existing data, from the Skills for Care Audit[13], provided information about specified types of training (indicating that 38% of staff had

undertaken dementia specific training), but did not collect information about all types of dementia training staff may have undertaken from the provider perspective. Whilst the What Works study did provide information from the provider perspective, this was not targeted to the social care sector and requires updating.

Our new evidence and data responds to these gaps, providing a sector specific view from both providers and recipients of dementia training. It deepens understanding of the extent and nature of dementia training being provided to the social care workforce, and the impact of training on the ability of the workforce to deliver high-quality care. It also proposes a series of tangible and practical evidence informed recommendations, with costs, to ensure that best practice training is delivered to the social care workforce in England.

RESEARCH METHODOLOGY

The information underpinning this report was collected by

METHOD 01

Online Audit

53 PROVIDERS
119 PACKAGES

- 53 Care home and home care providers reporting about 119 packages of training
- Included questions about the content of the training, delivery methods, reach and cost of training provided,
- The quality of the training being offered in terms of content and delivery methods was assessed against the Dementia Training Standards Framework
- Assessed against the five key components of impact-ful dementia training

METHOD 02

Online Survey

184 CARE STAFF

- Completed by 184 social care staff
- Included questions about training they have completed, knowledge and understanding of dementia

METHOD 03

Case Studies (x2)

1 CARE HOME
1 HOME CARE PROVIDER

- One care home and one home care provider
- In depth investigation of training offer
- Interviews with staff
- Interviews with care recipients and relatives

THE QUALITY OF DEMENTIA TRAINING FOR THE SOCIAL CARE WORKFORCE IN ENGLAND

WHAT DEMENTIA TRAINING CARE HOME AND HOME CARE PROVIDERS ARE OFFERING IN ENGLAND

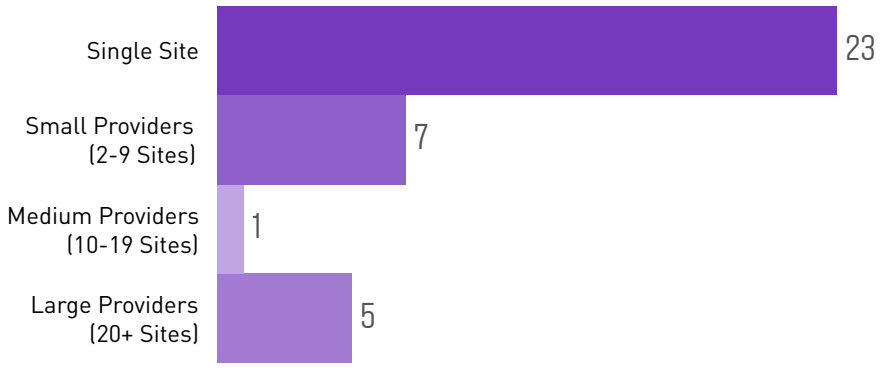
The quality of dementia training was assessed using an audit that was shared with providers with the aim of understanding the training delivered in the social care sector. A wide range of providers responded representing **648-720 care homes sites and sites with home care services**[b].

53 social care providers responded to the audit including 24 care home providers, 12 home care services, 14 public social services or local authorities, two training providers and four NHS trusts.

Of the 53 respondents, 23 of the providers represented single sites or regions (home care), seven represented small providers (2-9 sites), one medium provider (10-19 sites), and five large providers (20+ sites). The remainder of respondents did not specify or represented local authorities or independent companies/professionals (n=17).

FIGURE 1

Overview of the size of providers



b This is broken down as 241-278 care home sites, 254-289 home cares sites and providers who provide both with 134 sites. Data presented as a range due to response parameters in the audit.

The respondents were largely representative of the sector in terms of the size of the providers who responded. As of 2026 there are estimated to be 7,338 care home providers in the UK[18]. In England small to medium providers make up a significant proportion of the sector, with thousands of providers just having one care home, and just a handful of large-scale providers. 86% of social care providers in our audit were small to medium which corresponds to the sector.

Of the 53 respondents nine (17%) had 1-49 direct social care staff, nine (17%) with 50-99 staff, nine (17%) with 100-499 staff, six (12%) with 500+ staff and 20 (38%) who did not know.

44 providers who responded gave information in the audit about **119 different training packages**. Twelve providers (24%) reported about one package, with the rest reporting on multiple training packages: eight providers (16%) reported two training packages, 11 providers (22%) reported three packages, seven providers (14%) reported four packages and six providers (12%) reported on five packages.

Of the 119 packages, 97 (82%) were dementia specific training and 22 (18%) were more general training, or training on a different topic that included a dementia specific component (for example, training about the mental health act would include specific guidance related to dementia). Fifty-seven (48%) were part of a formal induction programme, and 62 (52%) were not. Frequency of delivery was explored, but for 29% of the packages this was not known, while 30% of the training packages had been delivered less than 10 times in the last 5 years.

For the 119 packages, 47% were bought in as outsourced training, 8% involved staff attending training off site with an external provider, and 37% were developed in house. Respondents to the audit estimated the reach of the 119 training packages for direct care staff without professional registration, around half of the packages (49%) reach at least 76% of their workforce.

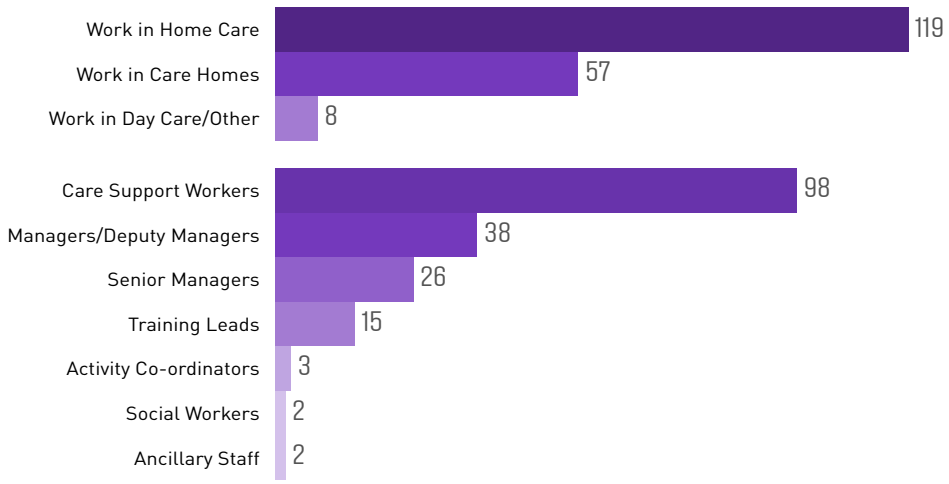
WHAT DEMENTIA TRAINING ARE THE SOCIAL CARE WORKFORCE RECEIVING IN ENGLAND

The staff survey targeted social care staff in England and asked about the dementia training they had received. A total of 184 responses were received. This included 98 care support workers or senior support workers, 38 managers, service managers or deputy managers, 26 senior management, 15 training leads, two ancillary staff, three activity co-ordinators and two social workers. Of the 184 respondents, 57 worked in the care homes and 119 in home care (8 staff in day care, as personal assistants or described as other).

FIGURE 2

Distribution of staff survey respondents by job role and service setting

(n= 184)



In total 64% of these staff had more than five years' experience, this was comparable with the Skills for Care data about the sector, in which 57% care home staff had more than five years' experience. Similarly, in our data 5% had less than a year's experience, comparable to the 7% in the Skills for Care data. The majority identified as female (88%) and white British (67%).

Just over half (55%) of respondents had completed dementia specific training, and up to 95% had completed any dementia training, with only 4% stating they had not, and 2% saying they did not know if they had or not. Critical to this report has been exploring the quality and level of the training that is provided, and whether this is sufficient to equip staff to deliver person-centred care.

ASSESSING THE CONTENT OF TRAINING

In England, the Dementia Training Standards Framework (2018), provides a best practice standard against which training for social care staff can be assessed in terms of the essential skills and knowledge required to provide a high standard of care.

The framework describes 14 topics (Appendix G) that are critical for the delivery of dementia care, with learning outcomes for each topic aligned to three training tiers based on a staff member's level of contact with people living with dementia:

Tier 1 comprises a single topic - dementia awareness and should be achieved by all staff working in all roles across health and social care. This includes staff in non-clinical roles such as administration, catering, cleaning, and transport.

Tier 2 is for those who have regular contact with people with dementia in their role and includes 11 additional core topics. For example, person-centred dementia care, health and well-being in dementia care and end of life dementia care.

Tier 3 is for those working in managerial and leadership roles and includes additional learning outcomes across the core topics at Tiers 1 and 2, plus two additional topics (research and evidence-based practice and leadership in transforming dementia care).

Not all staff working in roles that have direct contact with people living with dementia require the same degree of knowledge across all the subject areas. For example, someone working in memory assessment and diagnostics services would not need the same in-depth knowledge of end of life dementia care as someone working in a care home or acute hospital setting. Likewise care home staff might need a less in-depth knowledge of dementia risk reduction and prevention, which might be more essential for staff working in primary care services.

WHAT TRAINING CONTENT IS BEING OFFERED BY PROVIDERS?

In the audit, we explored the content of training care providers are offering to the social care workforce in England against the Dementia Training Standards Framework. Similarly, in the staff survey we explored the type and level of training care staff report they have completed.

It is recommended that direct care staff access training across relevant subjects at Tier 2, as Tier 1 (dementia awareness training) alone is not sufficient to equip staff to provide the right care for people living with dementia. In the audit, providers were given details of the Dementia Training Standards Framework and were asked to map the level and topics covered in the training against it.

KEY FINDINGS

1 **TRAINING LEVEL**

MOST PACKAGES ARE AT AWARENESS LEVEL ONLY

Most training packages offered by social care providers in England are at the Tier 1 dementia awareness level. Staff also most commonly reported receiving dementia awareness training.

2 **FALLS SHORT OF REQUIREMENT**

AWARENESS TRAINING ALONE DOES NOT MEET REQUIREMENTS

Training at dementia awareness level does not meet the Dementia Training Standards Framework requirements for social care staff in regular contact with people with dementia. Direct care staff need Tier 2 knowledge and skills.

3 **TIER 2 CONTENT**

WHERE TIER 2 EXISTS, IT FOCUSES ON PERSON-CENTRED CARE

Where Tier 2 training is available, it is predominantly focused on person-centred care and communication, interaction and behaviour — important topics, but only part of what Tier 2 requires.

4 **CRITICAL GAPS**

CRITICAL TOPICS COVERED BY FEWER THAN HALF OF PACKAGES

Equality, diversity and inclusion, families and carers as partners in care, and end of life care are covered by less than half of all packages. End of life care appears in only 23% of packages — a significant gap for a workforce supporting people through the final stages of dementia.

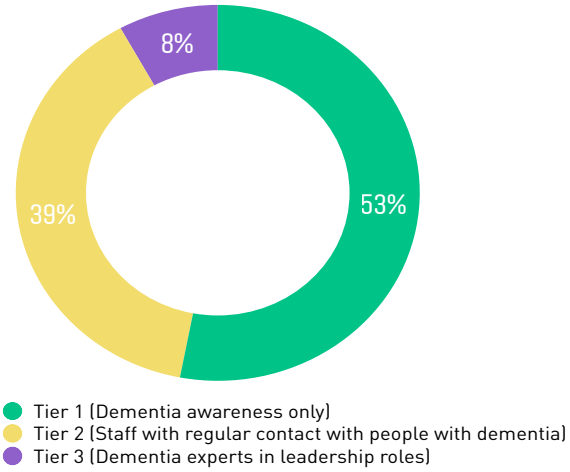
5 **INDUCTION GAP**

LESS THAN HALF OF STAFF RECEIVE DEMENTIA TRAINING AT INDUCTION

Only 47% of staff survey respondents said dementia training was included in their induction — meaning over half are starting work having not received any dementia training at all.

FIGURE 3

Overview of Tiers covered by training packages



TIER 1 · **AWARENESS**

53% 63 packages

Dementia awareness only — the broadest audience, covering all staff regardless of role.

TIER 2 · **CORE SKILLS**

39% 47 packages

For staff with regular contact with people living with dementia, including direct care staff.

TIER 3 · **LEADERSHIP**

8% 9 packages

Dementia experts working in leadership roles.

SOURCE: audit of 119 reported training packages · National Dementia Training Framework

In addition to the level of training, respondents were also asked to state which of the 14 Dementia Training Standards Framework training topics were covered in their reported packages (see appendix F, table 1 for overview). Of the 119 packages, 103 (87%) included the topic of dementia awareness training, further illustrating the prevalence of dementia awareness as a core topic for learners and its inclusion across the different tiers of learning.

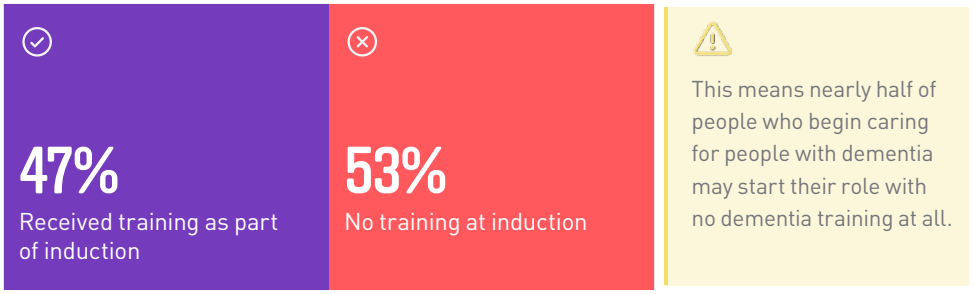
Other topics regularly covered in the packages were: person-centred dementia care, communication, interaction and behaviour (80%), living well and promoting independence (67%) and health and wellbeing (59%). Dementia identification, assessment and diagnosis was covered in 51% of the packages.

Topics covered by 50% or less of the packages included families and carers as partners in care (45%) and equality, diversity and inclusion (44%). A number of Tier 2 topics were covered by very few of the packages, specifically, end of life care (23%), pharmacological interventions (18%) and law, ethics and safeguarding (32%). All of these topics are critical to the delivery of social care support and play a significant role in the delivery of person-centred care. Some topics such as law, ethics and safeguarding could be covered in non-dementia specific training content, for example generic training on the Mental Capacity Act, that were not reported on in this audit.

WHAT TRAINING ARE SOCIAL CARE STAFF GETTING?

The above findings from the audit of providers were also reflected in the perspectives of the workforce from the staff workforce survey in which 80% of staff survey respondents reported that they had received some level of dementia awareness training. 55% said they had accessed dementia specific training (explored later in the section on training delivery). 53% said they had completed a Care Certificate which included dementia content **and only 47% of staff survey respondents said dementia training had been included as part of their induction, which means nearly half of people who start caring for people with dementia may have no dementia training at all** (Appendix F, table 2). It was encouraging to see that 32% had completed a formal qualification[c], which included dementia content.

Only half of new staff receive dementia training as part of their induction



The findings that only around half of staff had completed an induction including dementia content[d] or the care certificate aligns to previous research[18]. In England, The Care Certificate standards (TCC) were introduced in 2015, and represent a set of 15 generic standards relevant across health and social care designed to equip workers with basic skills and knowledge required to provide care. Within Regulation 18, the Care Quality Commission requires all registered care services to provide an induction that meets TCC Standards within 12 weeks of commencing post[19,20]. The aim is to promote consistency around induction processes and circumvent the need to retake induction training if staff move roles. Despite the regulatory requirement, an evaluation of TCC found that social care services were less likely to have implemented it than health care services. This same evaluation also found variation in the methods of implementation (how induction was delivered to meet these standards) which has led to uncertainty over the quality of TCC overall.

c E.g. NVQ, excluding qualifications for professional registration.

d Staff who were newer in role were more likely to have completed induction.

ASSESSING THE DELIVERY OF DEMENTIA TRAINING

The report Because We're Human Too[3] defined five key components for delivery of impactful dementia training:

1. EVIDENCE INFORMED TRAINING DESIGN

Training design should be evidence-based and reflect the lived experience of the diverse range of people living with dementia and social care staff. Training should be evaluated, with feedback used to refine and develop what is provided.

2. EFFECTIVE DELIVERY METHOD

A combination of interactive and engaging delivery methods are needed. Both face to face or online group learning can be effective, provided training is delivered by a skilled and experienced facilitator. Self-directed learning or lecture/talk style methods should not be used as the only teaching approach.

3. INCLUSIVE DIGITAL LEARNING

Any training delivered through digital technology must take into account the digital skills of learners and how accessible materials are in online formats. Social care staff need the flexibility to access digital learning on their own device.

4. SUPPORT AND ACCESSIBILITY

Training needs to be relevant to a learner's role, level of experience, literacy and skills. Coaching, mentoring, supervision and peer support are all essential for supporting staff well-being throughout the learning process.

5. STRONG LEADERSHIP

Impactful training is reliant on effective leadership, which supports implementation of learning into practice, and fosters an organisational culture that supports learning and development.

As outlined in the introduction, these components were used to assess training currently being provided to staff across the social care sector.

KEY FINDINGS

01 — EVIDENCE

54% OF TRAINING PACKAGES WERE EVIDENCE-BASED

But only 8% of those used the Dementia Training Standards Framework. Most training includes views of people with dementia, though only 32% involved them in development.

02 — DELIVERY

AROUND 50% OF TRAINING DELIVERED BY E-LEARNING

Over 60% of the training packages are 4 hours or less. Half offer only 1–2 hours of dementia specific content.

03 — INCLUSIVE DIGITAL APPROACH

E-LEARNING IS THE DOMINANT APPROACH TO DELIVERY

Despite e-learning being the dominant delivery method, only 11% of providers perceive digital access as a potential barrier to training.

04 — ACCESSIBILITY & SUPPORT

63% OF TRAINING IS DIRECTED TO ALL STAFF RATHER THAN BEING TAILORED TO SPECIFIC STAFF ROLES

Training is not being provided at the right level for direct care staff. Providers are also not offering support to access training such as translation.

05 — STRONG LEADERSHIP

MOST TRAINING PACKAGES DO NOT DEVELOP THE NEXT GENERATION OF LEADERS

The majority of respondents said their training did not support staff who could champion and lead implementation of good dementia care with leadership initiaves such as dementia champions.

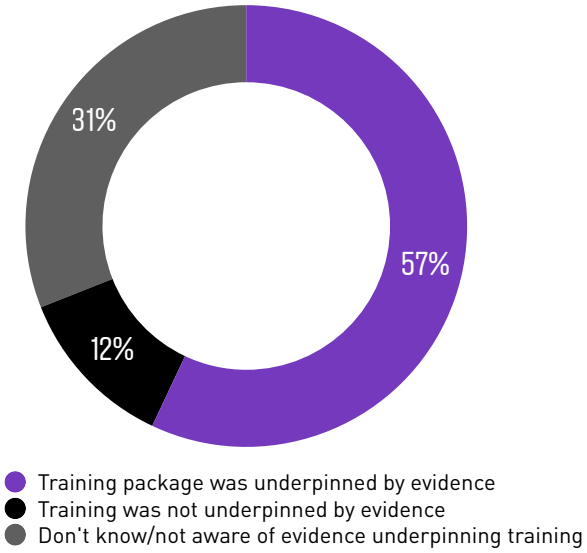
1. EVIDENCE INFORMED TRAINING DESIGN

Training design should be based on the best available scientific research, data and facts. It should also integrate expert knowledge such as professional expertise and lived experience. In England, the Dementia Training Standards Framework[2], which is underpinned by evidence, provides a benchmarked standard against which evidence-based training can be developed or measured.

Of the 119 training packages reported in our audit, 68 (57%) said the training package was underpinned by evidence, 37 (31%) said they did not know or were not aware of the evidence that underpinned their training, and 14 (12%) said their training was not underpinned by evidence. These findings suggest that around a third of training packages are not informed by evidence, creating a risk that these training packages do not meet best practice standards.

FIGURE 4

How many packages are evidence based



For the packages that were reported as being underpinned by evidence, a range of evidence sources were cited – most commonly research (24) (20%). Other evidence or frameworks were rarely used. For example, only nine (8%) used the Dementia Training Standards Framework and 10 (8%) were based on evidence from Dementia Care Mapping[e]. In summary, even where providers were reporting that their training was underpinned by evidence, very few providers were utilising evidence designed for this purpose, such as the Dementia Training Standards Framework, and of those that are, many of them are unable to expand on the evidence behind their training.

e Dementia Care Mapping is an observational data collection method for the purposes of staff development to provide feedback on person-centred staff – care recipient interactions.

Best practice training should reflect the lived experience of the diverse range of people affected by dementia. Our audit data indicated there is a good representation of the experiences of people living with dementia in training. A significant number of training packages included content reflecting the experiences of people with dementia, 106 (89%) included examples of lived experience in the materials and 38 (32%) of packages had involved with people with lived experience in their development. While it was good to see 19 (16%) packages including people with lived experience of dementia in delivery, support could be offered to help more providers directly involve people living with dementia in delivery. This would ensure that the experiences of a range of people living with dementia are reflected in training.

Training should also include some form of standardised assessment to help providers understand the impact of training on learning on the care that staff are delivering. Evaluation of the training is also key, and feedback from evaluations should be used to refine and develop future training provision.

Of the 119 training packages, 65 (55%) said they included an assessed component, whilst 50 (42%) said they did not. Out of the 65 that included an assessed component, 64 (98%) were assessed by questions to check understanding (e.g. a quiz), 13 (20%) observations of practice, 19 (29%) discussions of case studies, while two (3%) included in-person activities such as role play. Four (3%) of the respondents did not know if the training included an assessed component. These findings reflect that where assessment methods were used, these largely included short knowledge checks, for example a quiz, and generally did not consider impact of the training on staff skills or care delivery.

The impact of training on staff had been evaluated for 44 (37%) of training packages, it had not been evaluated for 51 (43%) of training packages and whether this had been evaluated or not was unknown for 24 (20%) of packages. Of the 44 (37%) of training packages that had been evaluated, this most commonly took the form of informal feedback from staff reported for 29 of the packages (66%), with 7 (16%) including an external evaluation and 22 (50%) internal evaluation. This represents a missed opportunity to ensure the ongoing monitoring and improvement of available training to ensure it is meeting the needs of staff, the organisation and the people they care for.

2. EFFECTIVE DELIVERY METHOD

Understanding the delivery methods that training employs is an important part of establishing the quality of training. The delivery of dementia specific training is a recommended approach for the delivery of topics aligned to Tier 2 and Tier 3 of the Dementia Training Standards Framework. Training is more likely to be impactful if it is delivered in-person or through a blended approach, provides opportunities for reflection on practice, is evidence based, targeted to staff member's role, and at least 8 hours duration[4].

DELIVERY OF DEMENTIA SPECIFIC TRAINING

In the 119 training packages reported in our audit, 97 (82%) were dementia specific training and 22 (18%) were more general training. This was assessed further according to the topics covered in the Dementia Training Standards Framework (Appendix F, table 1). Of the 87% of packages covering the topic of dementia awareness, 83% were dementia specific training and 17% were delivered as general training with dementia content. Similar patterns were observed across Tier 2 training topics, with fairly consistent patterns in terms of the proportion of topics being covered by dementia specific training and general training with dementia content. Both approaches to training delivery matched in terms of the most frequently covered topic (dementia awareness) and least frequently covered topic (end of life care). One notable difference was the topic of communication, interaction and behaviour, with 82% of dementia specific training covering this topic, compared to 68% of general training with dementia content.

Although the audit of providers showed a high proportion of dementia specific training packages (82%), this was not reflected in responses we received from the staff survey where we asked staff to report the type of training they were receiving.

From the survey of social care staff we found that only 55% of staff were receiving dementia specific training, highlighting a contrast between what training is available from care providers (82% dementia specific training) and what training is actually accessed by care staff. 95% reported getting any dementia training, including dementia content within generic training. Examples of non-dementia specific training included induction and The Care Certificate. These findings are important as they suggest that 40% of staff are getting dementia training by non-specific dementia training. This may be the primary method through which many staff are receiving dementia content, particularly in the first critical year or so of working in their organisation. This approach to training is unlikely to be sufficient to equip staff to deliver high-quality person-centred care, as generic training with dementia content is unlikely to meet the threshold for best practice delivery outlined in this report.

METHOD OF TRAINING DELIVERY

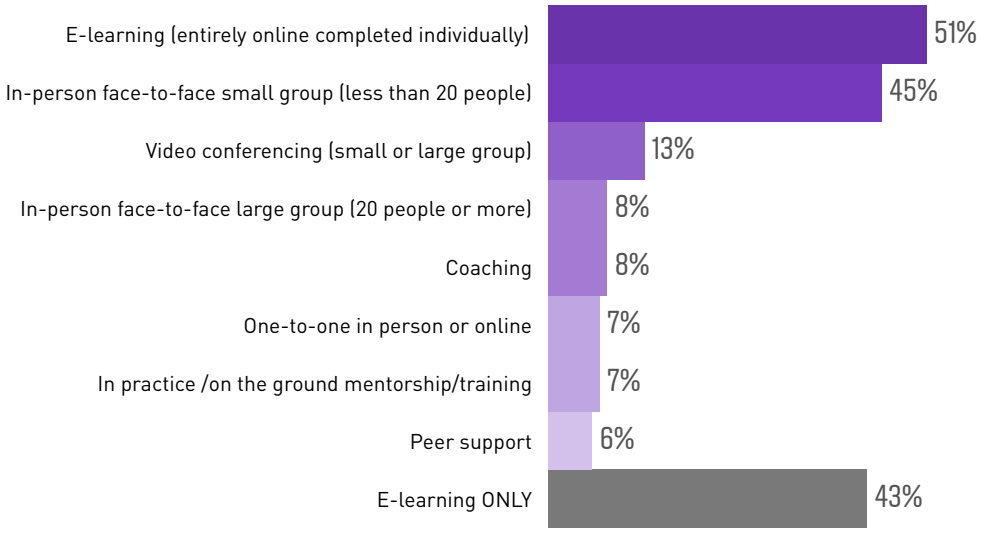
In our audit, over half, 61 (51%) of the 119 packages, were completed using e-learning - delivery that is computer-based without the input of "live" interaction with facilitators or other learners. Of the 61 packages reported, 51 (43% of all training packages) of these used e-learning as the only method of delivery. Research has shown that e-learning delivered in this way is less likely to be positively received by staff and is less likely to

provide them with the right knowledge and skills to be able to deliver good dementia care. In this audit, 71% of the e-learning reported was at the dementia awareness level.

In terms of the other delivery methods used – 53 (45%) packages were in-person, face-to-face, small group training[f] – aligning with a recommended delivery approach. Providers reported 10 (8%) packages used in-person face-to-face delivery in large groups, 15 (13%) used video conferencing, eight (7%) used one-to-one in-person or online, eight (7%) mentoring, eight (7%) coaching and seven (6%) peer support.

FIGURE 5

Method of training delivery



LENGTH OF TRAINING

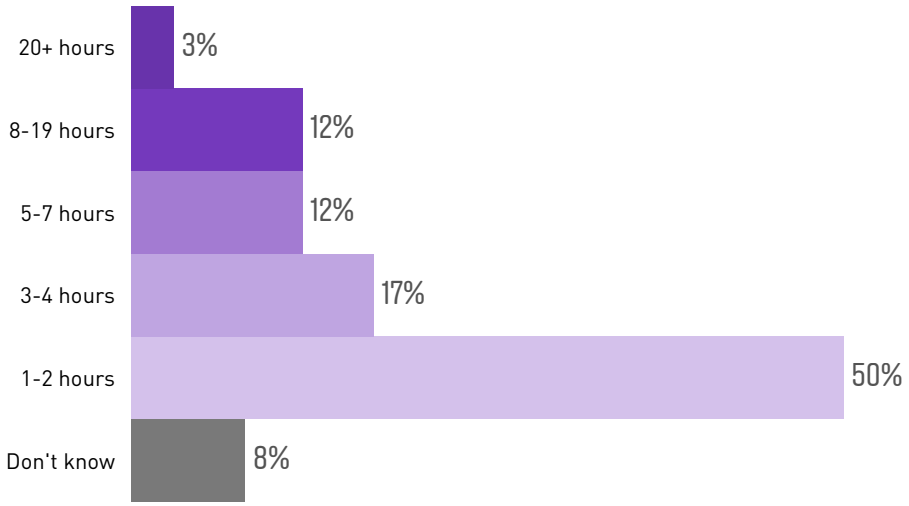
In addition to how training is delivered, duration of training is also important. For dementia training, the evidence-base indicates an overall training duration of at least 8 hours (over one or more sessions) is more likely to have a meaningful impact on learning[21]. This allows for the training to have sufficient depth which is more likely to have an impact on staff knowledge, skills and confidence to deliver good dementia care.

Of the 119 training packages, 86 (72%) were standalone sessions, and 33 (28%) included more than one session. Across the reported training packages the hours of content specifically focused on dementia varied from 1-2 hours to 40+ hours. 59 (50%) packages offered 1-2 hours of dementia specific training content, 20 (17%) offered 3-4 hours dementia specific content, 14 (12%) offered 5-7 hours, 14 (12%) offered 9-19 hours, and three (3%) offered 20+ hours. Therefore only 15% clearly met the best practice threshold of more than eight hours training. Furthermore, a larger proportion of the e-learning only training was of shorter length, with 67% of training delivered by e-learning lasting only 1-2 hours. These findings suggest that if these packages are the only dementia training being provided to social care staff, the training provided is not sufficient to be having a meaningful impact on their dementia knowledge and skills.

f Small groups fewer than 20 people, large groups 20 people or more.

FIGURE 6

Length of training



TRAINING FACILITATOR

Research shows that good quality training should be delivered by an experienced training facilitator who understands dementia care practice and the realities of delivering dementia care in that setting[22]. Training delivered in this way can lead to higher learner satisfaction and the ability to tailor training to the needs of individual groups of staff attending. In the audit 49 (41%) of the packages were delivered by external trainers, 47 (39%) were delivered by in-house specialist trainers, nine (8%) by in-house clinical/other staff, and 13 (11%) by in-house dementia champions. Overall, 69 (58%) packages were delivered by in-house staff.

While over half (58%) of reported training packages were delivered through in-house staff, many providers reported outsourcing the delivery of some training packages to external providers. Use of external training providers (41%) can bring important topic expertise and training facilitation experience, which providers may not have available in-house. However, use of external providers may be less beneficial where the purchased training is not tailored to the organisation and support for implementation is then not available in practice. Externally provided training usually also carries higher costs. Our case studies, detailed later in the report, provide examples of working with external providers initially or on an ongoing basis, to draw on evidence or expertise, within an overall strategy to develop relevant internal expertise for the training to become part of the organisational philosophy as an embedded training offer.

3. INCLUSIVE DIGITAL LEARNING

Despite e-learning being the most often used method of training delivery (51%), the audit indicated access and support for technology-based learning is not being widely considered in the sector, with only 11% of providers[g] identifying access to digital devices as a perceived issue. Where training was delivered by home care providers and contained digital components, we asked whether trainees were supported to access this[h]. Three respondents to this question said they provided devices to staff, two said they covered costs (e.g. wifi, purchase of equipment), however, seven said staff were expected to use their own digital device and no costs were covered by the organisation. This suggests staff may be completing training on their personal devices and at their own expense. Bearing the cost of the training is an inappropriate expectation and may act as a barrier to engagement.

4. SUPPORT AND ACCESSIBILITY

The audit shows that most training packages being offered by social care providers in England are at the Tier 1 dementia awareness level, which is not the appropriate level for staff working in settings where they have regular contact with people with dementia.

The audit asked which staff groups each of the training packages were intended for. Of the 119 packages, 75 (63%) were targeted to all staff groups (i.e. anyone working in the provider organisation including senior management and ancillary or administrative staff), with 37 (31%) specifically aimed at direct care staff without a professional qualification, and 22 to staff with professional qualifications (e.g. nurses). In terms of accessibility, we would expect training to be targeted to the learner's role and their staff group.

In addition to its level, the accessibility of the training is an important feature of best practice. Providers gave information on accessibility for 53 training packages. Translated materials were provided by 17% of the providers, and translation services were only provided by 4% of providers. This is despite 19% of providers citing language or cultural needs of staff as a barrier to training (see table of barriers and facilitators to training, appendix F table 3). In addition to accessibility, 36% of providers said they do not offer support to access or understand training, and 32% that it wasn't applicable.

5. STRONG LEADERSHIP

Impactful training is reliant on effective leadership which supports implementation of learning into practice and fosters an organisational culture that supports learning and development. Strong leadership can be exemplified by schemes such as dementia champion schemes. Most training packages (80%) did not include opportunities for the development of staff who could support and lead implementation of good dementia care, such as dementia champions. 21 (18%) of the 119 training packages included the opportunity to train staff to be dementia champions. Of these 17 (81%) said all staff were eligible to be trained as dementia champions, while three (14%) specified direct care staff only were eligible.

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g when the n=53 providers were asked about barriers to training

h 12 providers responded to this question

WORKFORCE KNOWLEDGE AND ATTITUDES

The social care workforce requires best practice dementia training to ensure sufficient knowledge and understanding about dementia. It is also vital to recognise just how important attitudes towards dementia are – individual attitudes and beliefs (such as holding stigmatising views about dementia), can act as a barrier to learning and motivation to improve practice[23]. Care staff's attitudes towards dementia can also impact on the care they deliver. Training direct care staff can deliver improvements in confidence and belief in their own ability to care for and build compassionate relationships with people living with dementia[24]. Good quality dementia training can increase staff competency and attitudes towards dementia[25]. When combined with organisational support, training can lead to improved communication, increased levels of activity, less task-focused care and importantly, an increase in wellbeing of care recipients[22].

For these reasons, training should affect attitudes as well as knowledge about dementia. Research shows, that regardless of topic or length, training produces basic but positive impacts on staff-reported confidence, knowledge and attitudes to dementia and person-centred care [26-29]. In this report we explored staff knowledge and attitudes using both standardised measures of knowledge and confidence and creative approaches.

KEY FINDINGS

KNOWLEDGE

- A third of staff do not have consistent levels of basic dementia knowledge
- Some staff show the ability to apply knowledge about real-world person-centred care practice — but not all staff can demonstrate this

ATTITUDES TO DEMENTIA

Some, but not all staff show values aligned to person-centred care

CONFIDENCE

Only 52% feel very competent in the care they provide

ATTITUDES TO TRAINING

- Staff felt that training had a direct impact on their ability to deliver care
- Staff would like more dementia training

Despite 95% of staff accessing any dementia training, the standardised test of knowledge that we delivered in the survey indicated that around one-third (35%) of staff do not have dementia knowledge that is aligned to what is considered basic knowledge of dementia, illustrated in the responses to the Dementia Knowledge Scale below.

Our survey of the social care workforce asked participants (n=184) to complete the Dementia Knowledge Assessment Scale[30]. This involves answering statements about dementia which are rated as true or false. The survey only included the DKAS components relating to communication and behaviour and care - these statements reflect a basic level of dementia knowledge that should be gained through completion of dementia awareness training.

Whilst nearly 60% of respondents answered the questions around care considerations, communication and behaviour all or majority correctly (10-12 points out of a maximum 12), 24-27% of respondents only answered them mostly correctly (7 to 9 points) and 8-11% answered less than half correctly. This indicates that although the majority of survey respondents had completed some kind of dementia training, levels of basic dementia knowledge are still moderate (around 25%) to low (around 10%) for around 35% of social care staff.

This corresponds to previous research findings[22] that indicate whilst any training may increase knowledge, the degree to which this uplift in knowledge happens, depends on the quality of the training that is offered. Should all staff have completed training in dementia care of sufficient quality, we would anticipate all staff achieving scores on the DKAS that were all or majority correct (score of 10-12). Since the DKAS asks questions at a basic dementia knowledge level (aligned to Tier 1 knowledge), and may be subject to ceiling effects, we further interrogated knowledge of person-centred care practices using a storyboard approach at the case study sites, described in the upcoming section of this report, enabling staff to express a higher level of applied dementia care knowledge (Tier 2 and 3).

The survey of the social care workforce also required staff to reflect on their perception of the training they had undertaken, and its perceived impact on their knowledge and ability to care for people with dementia. Staff who responded to the survey also reported on the impact of the training that they had received.

Most (81%) staff agreed or strongly agreed that they had received sufficient dementia training to enable them to care for people with dementia. Further, 85% strongly agreed or agreed that the training they had completed had equipped them to better care for people with dementia, whilst 11% disagreed with this sentiment and 4% remained neutral. However, the wider findings of this report suggest that staff are not in fact being given training at the right level to deliver good quality person-centred care and staff do not have consistently high levels of knowledge. Taken in the context of the literature cited previously, these staff reflections are consistent with the notion that for staff coming to a caring profession with very low levels of knowledge and understanding of dementia, any dementia training (no matter the level or quality) will enhance knowledge and attitudes, and make staff feel more equipped to support people. This strengthens the case for the use of objective measures of knowledge that assess the impact of training, rather than relying on reflection of staff who have undertaken the training as an indicator of quality and impact.

This interpretation of the findings is further supported by the results from our workforce survey where 81% of staff agreed that they would like more dementia specific training. Furthermore, when asked questions about their Sense of Confidence In providing Care for people with Dementia Scale (SCIDS[31]), only 52% reported feeling very competent in the care they are providing (scoring 61-68). These findings are indicative of a clear need for the provision of dementia training that is targeted and specialist, to equip learners to feel confident in the care that they are delivering, which is the minimum that people who draw on care should expect from the workforce who are supporting them.

A STORYBOARD APPROACH TO EXPLORING STAFF KNOWLEDGE AND ATTITUDES

In addition to exploring staff knowledge and attitudes in our survey, we worked closely with our lived experience involvement group (LEIG) to develop storyboard vignettes that represented care delivery scenarios (the story of Arthur) of care home and home care provision. The aim of the storyboard was to interrogate staff knowledge of person-centred care practices enabling staff to express a higher level of applied dementia care knowledge (Tier 2/3), than possible using standardised scales. The stories were based on their own experiences and reflections and were designed to create opportunities for staff to be able to reflect on and identify poor care or opportunities to improve care. This was designed to complement the measures of knowledge and understanding that were obtained from staff in the survey but also allowed for a more in-depth appraisal of person-centred care practice. An example image of the story board (for home care) is presented below. An equivalent story board was created for a care home setting.

FIGURE 7

Example of Storyboard

We interviewed staff at the case study sites described later in this report. One case study site was a care home, and one was a home care provider. At each case study site, up to five staff interviews were conducted. At the end of the interview staff were asked to read (or were read) the story board, to give their views on the care Arthur was given, and if they would do anything differently if they were providing care to Arthur.

The responses that staff gave have been analysed by researchers guided by the LEIG, who have provided their views on elements that the staff were proficient in picking up on, as well as where there may have been opportunities for improving Arthur's care that were overlooked or considered differently.

Most staff at both of the case study provider sites (A&B) identified that the care Arthur received fell below the standard they would expect in their own practice.

> *"Every sentence enraged me. Oh, my God. I can't remember the entire thing, but off the top of my head, definitely. I mentioned this before. It's what is easier for them and the not the best option for the person."*
> (STAFF PROVIDER B HOME CARE)

Specifically, care staff identified opportunities that they would have taken to deliver better care, which were clearly underpinned by a holistic and person-centred approaches. This demonstrated an understanding among staff of how to apply principles covered within dementia training into day-to-day practice.

> *"obviously this chap would, you know, likes to do maintenance, we have maintenance chaps that work here as well, really good with people. So they could be doing a couple of hours maintenance, whether it's painting a fence, painting a chair, you know, whatever."*
> (STAFF PROVIDER A CARE HOME)

And some clearly identified the importance of and missed opportunities for involving the family. The LEIG did identify that not all staff were able to pick up on this in the interviews – so it was really important when they did.

> *"[the] culture…here…with relatives…it's very good. I mean they can speak to the manager, we also have forms that they can fill in but to be honest we're just one massive family here…the manager's door is always open. There's always somebody here for them to talk to if they want anything."*
> (STAFF PROVIDER A CARE HOME)

Examples from home care similarly picked up on the fact that the vignette included lots of opportunities to involve Leanne (Arthur's wife) in his care planning and delivery, that were missed. Staff from the case study sites gave clear examples of what they would do differently:

> *"The family should be able to talk to the carers, let them know he wants a slower morning. How can we make that happen? If we can't make it happen in the time that we're being allowed… There's so many things wrong, too many things*

> *wrong ...when we introduce like the company will send a profile of the care professional to the family so the family will see who they're getting they'll read a certain information about them you still have to meet the person you still have to get along with them you don't always gel with different characters you could go there and the two of you despite trying to work together might be like chalk and cheese and they just don't respond to you and if that's the case, you want someone that will put them at ease and they will respond to."*
> (STAFF PROVIDER B HOME CARE)

However, some staff gave answers that suggested they may lack a depth of knowledge about person-centred approaches and how to apply them in the context of dementia care. For example, through being able to identify poor practice but not being able to give examples of potential good practice solutions, or by discussing general care approaches which lacked the specific details of how this might be put into practice:

> *"I wouldn't take try and take away his independence, I'll try to get him involved in maybe his personal care or making his lunch or making his dinner"*
> (STAFF PROVIDER B HOME CARE)

Sometimes the solutions that were suggested were not reasonable or realistic, and placed solutions outside of the responsibility of the staff member. For example, a few staff members (in the home care vignette) stated that a longer visit for Arthur may be needed. But the LEIG members pointed out that it might be nice to identify what could be achieved in 15 minutes with creative solutions, as well as identifying that a longer visit would be ideal.

IMPLEMENTING BEST PRACTICE DEMENTIA TRAINING

WHAT DOES BEST PRACTICE DEMENTIA TRAINING LOOK LIKE IN ENGLAND?

Case studies of training were conducted with two care provider organisations. The case studies explored the available training programmes, and interviewed people who draw on care and staff members about their views on training and experiences of receiving or delivering care.

The sites were selected from respondents to the audit who demonstrated indicators of best practice training that were aligned to the five key components of high-quality training delivery as defined in Because We're Human Too[3]

CASE OVERVIEW

PROVIDER A CARE HOMES

CARE HOME GROUP · 4 SITES

PROVIDER TYPE
Residential / Nursing

TRAINING MODEL
Hybrid - External + in house

IN BRIEF
External expertise brought in house. Whole-organisation relational philosophy. Low staff turnover as evidence of success.

95%

of staff have completed at least one in-person training course

COMPONENTS MET

- Evidence informed training design
- Effective delivery
- Strong leadership

SUMMARY

This case study demonstrates how a hybrid approach of drawing on the expertise and input from external training organisations and bringing this in house has led to the whole organisation embracing an evidenced based approached to training and philosophy of care that is evident across the organisation.

BACKGROUND

This small to medium care home company has four residential or nursing homes, all providing care to people living with dementia.

The training comprises an online induction which includes dementia specific training, as well as three different packages of dementia specific in-person training for all staff to complete annually. One of the in-person packages focuses on relational care, and the other two provide in-depth person-centred dementia training. The two company directors (one clinical and one non-clinical) have been trained and accredited in delivering these training packages by an external training provider. The company have an ongoing relationship with the two external training providers, who accredits the training delivered. Almost all (95%) staff within the organisation have received at least one of the in-person training courses and 65% have completed both programmes.

EVIDENCE INFORMED TRAINING DESIGN AND CONTENT

The training this provider offers is embedded in a relational philosophy that the whole organisation has adopted, which involved a top-down culture change process that has been taking place over a number of years. One of the managing directors described difficulty at first getting to grips with the approach, which was a stark contrast to the biomedical and task driven stance that had dominated the sector for years (they first adopted this training in 2011). However, once they as directors had got to grips with it the process of cascading this down was transformational:

> *Once we actually took it [the training] … ourselves and really got it, …we then had to work on managers who were very similar to us really thinking, 'Oh well, we do all that already', but actually they …didn't do it So that started a number of years of, really trying to embed this new culture, a new way, sort of seeing the world if you like…it's focused on addressing loneliness by creating …an environment of loving companionship. We address helplessness by trying to work in partnership, and we address boredom by trying to create an environment [with], the variety, funds, sponsorship, quality of life being there.*
>
> (MANAGING DIRECTOR CARE HOME SITE A)

The process of organisational change and embedding this approach to training was at first met with reticence but soon empowered staff to take control and ownership of their care environment.

> *And so that came with regular training, regular talking about it, ...embedding it ... alongside with empowerment and autonomy for people. So releasing those reins of control and really just seeing people flourish, ...with ideas and ways of doing things which [were] different.*
> (CLINICAL MANAGING DIRECTOR CARE HOME SITE A)

Part of the philosophy involves working with people with dementia and staff, and listening to them, so iterative feedback is described as built into this approach. Additionally, because the training is about the home adopting a wholesale philosophy, each home is also audited by the external dementia training organisation with which the provider has a relationship. This has been described as positive by staff, as something they especially value, since it provides feedback on the positive care that they are providing.

> *The auditor comes in and spends a couple of days and watches the staff, how they interact with people, and the delivery of the care ...Relatives give statements, on the different things that we do. Then we get awarded at the end of it, so it's a lot, it can be a long process ...but when you've got the gold star as they say, you feel really proud*
> (STAFF MEMBER CARE HOME SITE A)

EFFECTIVE AND INCLUSIVE DELIVERY METHOD

Even though the provider offers the e-learning awareness training at induction, they perceive this type of training as meeting a minimum mandatory standard (of dementia awareness) on which they build. The perception being that this level of training is more mechanistic than meaningful. The important or impactful training is viewed to be training which is delivered in-person, in-house, in this case by the by the director and clinical director.

> *We do ..basic living with dementia, dementia awareness and we do that online through [x]., but we don't tend to get too excited about the mandatory stuff, although people find it interesting and we get good compliance, as people like it, but it's not kind of reaching to the heart. It's more mechanistic.*
> (MANAGING DIRECTOR CARE HOME SITE A)

The in-person courses are well attended, with 95% of staff having attended a course covering relational care annually, and most staff also receiving an additional course on person-centred care. These courses are seen as an important opportunity and space for the staff to learn and reflect.

> *[it] becomes quite a social thing. You know it's something to look forward to .... Another thing is that to make the training relevant, a good chunk of it. ... has to be about reflection. What are we doing and how's this working? What did go well? What didn't go so well?*
> (MANAGING DIRECTOR CARE HOME SITE A)

The directors value the positive feedback received by staff.

> *And I think that if you've got the team on board and they really want to do something, you're halfway there, you know, and we didn't have any of this. "Oh, we haven't got time" and "we haven't got this, we haven't got that." It [the feedback] was a very proactive, positive.*
> (MANAGING DIRECTOR CARE HOME SITE A)

This is echoed by staff attending the training, who described it as transformational to their attitudes and practice:

> *I think it's very emotional. It makes you think. It makes you change your insight, really. Because, you know, when I first started care, it was very much, you did it and you come home. So you literally would have walked in and you would have given them breakfast. You would have taken people to the toilet. You would have given them lunch. There was no bonding with people. There was no relationship with people.*
> (STAFF MEMBER CARE HOME SITE A)

STRONG LEADERSHIP

The training approach adopted by Provider A that has been developed alongside committing to a distinct philosophical approach, that provides the underpinning principles of the overall programme. As outlined by the managing director:

> *[the] Leadership model, which is another part of the principles, is very much a service leadership model in [programme name], not a kind of control hierarchical model. So [programme] talks about the inverse pyramid of control. You know, boss [at the top], workers at the bottom. Invert that, the boss is underneath the pyramid, if you like, trying to balance the whole thing on his/her head and his/her job is to serve the greater good... so I guess our attention has changed radically and we're still evolving ... over the years ...our attention has increasingly gone towards the team, as well as the residents.*
> (MANAGING DIRECTOR CARE HOME SITE A)

Provider A described this whole system approach as underpinning the success of their training in terms of the impact that it has had on the residents and their service as a whole. This includes the general happiness and well-being of staff members, and low turnover of staff, including care home managers, as being indicators of this success.

> *It was the ... more senior care team who really embraced this because it was something that they ... really enjoy doing ... and we've still got ...managers we've had for 17 years. Manager 1 has been there since '92. Manager 2 and 4, 2004.....*
> (MANAGING DIRECTOR CARE HOME SITE A)

CASE OVERVIEW

PROVIDER B HOME CARE GROUP

NATIONAL · FRANCHISE MODEL

PROVIDER TYPE
Domiciliary / Home Care

TRAINING MODEL
Blended – centralised platform

IN BRIEF
Centralised platform enables flexible learning. External expertise embedded into in house content. Dementia champions course builds org-wide capacity. Staff value the "dip in and out" model.

10.5 hrs
length of training exceeds 8 hours best practice standard

COMPONENTS MET

- Evidence informed design
- Inclusive digital learning
- Support and accessibility
- Strong leadership

SUMMARY

This training offer demonstrates a suite of training that has been developed in house, but with expertise bought in externally where required, especially in the initial phases, to ensure that the training is contemporary and evidence based. The multilayered approach – from induction to dementia champions, demonstrates an organisational commitment to a whole systems approach and commitment to learning. This is echoed in the feedback from staff. Staff particularly valued the ability to dip in and out of learning as needed, which has been facilitated by the organisation's use of a technology and learning platform, which they identified as especially useful for the home care workforce.

BACKGROUND

This large, national domiciliary care provider operates on a franchise model, with a centralised training offer. All staff receive dementia training also as part of the mandatory induction. In addition, staff undertake a dementia specific training programme which was developed in collaboration with a dementia specialist who specialises in-person-centred dementia care practice. This has been reviewed and revised over several years, bringing in other providers and partnerships for expertise on specific topic areas (e.g. end of life care).

> *During our induction we have a session that's called day in the life of Betty. And that day in the life has scenarios within that as well. So right from the beginning …every carer within Provider B is introduced to training around, … supporting a client with dementia*
> (FRANCHISE MANAGER HOME CARE SITE B)

There is also a dementia care champions course available to staff, including care professionals, field care supervisors, care managers, schedulers and other members of the office team. The dementia care champions training is a blend of virtually delivered sessions and e-learning modules.

EVIDENCE INFORMED TRAINING DESIGN AND CONTENT

This provider described how the development of the dementia training programme has involved engagement with a range external experts to ensure that it is evidence based:

> *We always like to engage in subject matter experts, so we have a really good relationship with it's called the [redacted] partnership, …and they also have a specialist dementia team . So we collaborated with them for their .. knowledge because we wanted to make sure …whatever is in the training … is current best practice. You know [that] there's nothing in there that … is old hat or isn't …to date*
> (CENTRAL TRAINING LEAD HOME CARE SITE B)

They also described and recognised the importance of ensuring that the training aligned with best practice guidance (e.g. the Dementia Training Standards Framework informs the dementia champions course).

EFFECTIVE AND INCLUSIVE DELIVERY METHOD

The dementia programme is delivered by blended learning, with an initial dementia awareness module delivered purely through e-learning which is centrally hosted and modules 2-4 that are interactive and can be delivered online or in-person, and the last module requiring face to face delivery. In its entirety the dementia programme is of 10.5 hours duration.

The blended approach works well in home care as it offers flexibility for learners.

> *What the care [staff] like about it is the flexibility and the accessibility because it's such a blended approach. That they're not having to come into the office all the time, because some offices have massive territories, they might be in a very rural area or even in London. They struggled to get carers coming into the office, so it does make it much more accessible. The final module with the scenarios, that is face to face .. because we just felt it was important to have that face to face session. ..virtual delivery is, ..fine, but you ...never really get that, that rapport and those questions asked, etcetera. So we really felt it was important just to have that that finish ...with a face to face.*
> (CENTRAL TRAINING LEAD HOME CARE SITE B)

This is echoed in feedback from staff who value the flexibility of the approach, and the fact it enables "refreshers" of knowledge. The staff also said that the training was beneficial since it included realistic scenarios on client needs, what their lives may be like, and how to learn from them.

Although having recently completed an in-person day, one staff member noted that they had completed an online refresher training the previous week and had applied that training to real situations, such as reassuring a client who was having hallucinations.

> *That's what I would say that has played a vital role ...coming out from that training. You know, implementing those actions ...and it is actually helping the clients and they're very happy.*
> (STAFF MEMBER HOME CARE SITE B)

In general staff value the flexibility and ongoing nature of the training offer.

> *You'll do your refreshers online and you will listen to people that will go through various scenarios and ...ask you questions about 'do you think in this instance x y and z'. ....other times you're listening to a s... short film about support or, ... how something was done and then it would go through what could have been done differently? So it is it is good. It does keep you knowledgeable.*
> (STAFF MEMBER HOME CARE SITE B)

Staff also noted how the organisation provided support and training for them in response to the needs of the client.

> *So basically I have …a client who has mixed dementia and she's non-verbal …I learned about using flash cards and makaton and just different things …like music … different ways of communicating with her and actually penetrating her mind a little bit better.*
> (STAFF MEMBER HOME CARE SITE B)

STRONG LEADERSHIP

The provider was proud of the dementia champions offer, and felt that this underpinned the philosophy and success of their approach:

> *For our key players, … the people in the offices the care managers, the schedulers, the field care supervisor, etcetera, we didn't have anything in place for them. So, the [dementia champions] course, it's 16 hours studying in total, so there's two full virtual days separated by a week. And then there's another four e-learning modules for them to complete, And the feedback we get is that it helps those people …. understand the impact [of] some of their decisions.*
> (CENTRAL TRAINING LEAD HOME CARE SITE B)

WHAT DOES BEST PRACTICE DEMENTIA TRAINING MEAN TO PEOPLE LIVING WITH DEMENTIA IN ENGLAND?

In both of the case studies we spoke to up to five people who draw on care in each organisation, conducting individual interviews in-person or on the phone. We were keen to explore their views on dementia training and the care experience they received.

In general, the care recipients at both sites reported satisfaction with the care that they were receiving – citing specific examples of person-centred approaches. However, there were some indications that in some cases the nature and delivery of care fell short of their expectations. To explore what could be done better, or what they felt should be a training priority, we asked about their views on dementia and what would be important to include in training. They reported that, as well as communication, values and trust were cited as very important – particularly for home care providers, dealing with the sensitivities and responsibilities of entering an otherwise personal space:

> *"Just feeling you can trust them, which, you know, I do. I feel like I'm lacking in here…It's nice to be able to talk to people, feeling that you've got somebody listening and understanding you, which is mainly how it is. More so with some than others."*

WHAT DOES BEST PRACTICE DEMENTIA TRAINING COST IN ENGLAND?

So far, this report has highlighted our assessment of the quality and reach of current dementia training for the social care workforce. We've also outlined, using previous research, the key components of best practice dementia training. We have learnt that dementia training is being provided, but it is not at the level or depth required - current training is dominated by awareness level e-learning and is often very short in duration.

To better equip the current and future social care workforce, we need to progress from training that provides awareness, to training that provides the depth of understanding required to provide direct high-quality care to people living with dementia.

A further aim of this report was to explore the cost of training as it is currently provided and the cost impact of ensuring all care staff working with older adults receive best practice training.

COSTS OF CURRENT TRAINING

We estimated the current average total cost of dementia training for a care worker in England using data provided from our dementia training audit across all three nations (England, Wales and Northern Ireland). An explanation of what is included in these costs, and how our audit data was used to calculate them, is outlined in Appendix E. These costs do not include any additional costs of staff cover to support colleagues to attend the training during their usual shifts, rather than to attend paid training programmes on scheduled days off. We recognise that this is a cost incurred by some but not all providers.

The table below provides the estimated average total cost of training in England by training course type, assuming an average training duration of 4.96 hours. The costs vary per training course type and demonstrate that e-learning is cheaper to deliver than in-person training (internal or external). External training is also more expensive than delivering internal training.

TABLE 1

Estimated average cost of dementia training for a care worker in England, by training course type

NOTES

In-person and Overall presents the average cost of training for the (weighted) average in-person (i.e., external and internal) and overall (i.e. e-learning, external and internal) course delivery type, respectively.

TRAINING COURSE TYPE	AVERAGE TOTAL COST
e-learning	£60.80
in-person (weighted average)	£136.75
external	£217.82
internal	£73.60
OVERALL	£126.83

Average staff cost for attending training is **£60.47** in all estimates.

Whilst the above costs are based on a duration of 4.96 hours training average length of training (based on responses to our audit) we know that the most commonly reported duration of training recorded by providers in our audit is 1-2 hours. Additionally, the most often reported course type is e-learning. It was particularly interesting to examine the cost of e-learning lasting 1-2 hours, as it is known that e-learning training is not an effective method of learning, and 71% of the training delivered by e-learning only in our audit was described as awareness raising, rather than in depth training, and 67% of the e-learning only training was only 1-2 hours in length.

Applying this duration of training (1-2 hours) shows a lower cost. The table below also suggests that providers in our audit, who are most commonly only providing 1-2 hours of e-learning, are spending as little as £18.05 per staff member on dementia training:

TABLE 2

Estimated average cost of dementia training for 1-2hrs for a care worker in England, by training course type

NOTES
In-person and Overall represents the average cost of training for the (weighted) average in-person (i.e., external and internal) and overall (i.e. e-learning, external and internal) course delivery type, respectively.

TRAINING COURSE TYPE	AVERAGE TOTAL COST
e-learning	£18.05
in-person (weighted average)	£89.68
external	£175.06
internal	£23.15
OVERALL	£80.32

Average staff cost for attending training is **£17.72** in all estimates.

COSTS OF BEST PRACTICE TRAINING

To estimate costs of best practice training, we have focused on key components that are grounded in research such as 8 hours training duration and in-person delivery. In-person delivery can be either face to face or online real time interactive learning with a facilitator. Based on the data in the audit the costs for this best practice training approach are presented below:

TABLE 3

Estimated average cost of best practice, in-person dementia training for a care worker in England

NOTES
In-person presents the average cost of training for the (weighted) average in-person (i.e., external and internal) course delivery type.

TRAINING COURSE TYPE	AVERAGE TOTAL COST
in-person (weighted average)	£174.88
external	£254.79
internal	£112.63

Average staff cost for attending training is **£97.44** in all estimates.

Whilst these costs for best practice training are higher than the costs of training currently being delivered, we have shown earlier in this report that current training is not translating into the confidence, knowledge and attitudes that we would expect for a workforce who are directly delivering dementia care. What's also clear from our survey is that we have a workforce who want more dementia specific training.

THE COST GAP

To estimate current costs of dementia training to the sector at a national level, estimates were required on the number of staff trained. Data from the audit suggested that the average training course in the sample had been completed by 77% of direct care staff. We then multiplied estimates of the total direct care workforce in each country by this estimate of proportion trained, assuming it was constant across countries. For England, total direct care staff was the total number of FTE direct care staff as per national estimates from Skills for Care (2025), this is 915,000.

For best practice national cost estimates, we further assumed that a certain proportion of staff will be working in adult social care for younger adults and will not require dementia training.[i] We estimated this to be equal to 8% of staff from Department of Health and Social Care (2025) data on number of residents in younger and older adult care homes, respectively.[j]

We multiplied the estimated number of staff that have been trained or requiring training (for best practice) by the relevant per staff member cost. For current training, this was the overall average cost of training, weighted by the proportion of training available in the three delivery modes.[k] For best practice, this was the in-person average cost of training for an 8-hour course, weighted by internal and external delivery mode.

This resulted in the following estimated total cost of current training compared to the best practice approach:

TABLE 4

Estimated total cost of current training of direct care social care staff compared to the best practice approach

TOTAL STAFF COST	TOTAL TRAINING DELIVERY COST	TOTAL COST OF TRAINING
CURRENT TRAINING **£43.0m** (£31.8–54.2m)	CURRENT TRAINING **£47.2m**	CURRENT TRAINING **£90.2m**
BEST PRACTICE **£82.0m**	BEST PRACTICE **£65.2m**	BEST PRACTICE **£147.2m**

NOTES

Estimates based on the 'Overall' average cost per staff member. 95% confidence intervals for total staff cost of current training are provided in parentheses.

i This may then exclude from calculations any adult social care direct care workforce who support those with young onset dementia. We assumed this to be negligible in terms of national cost calculations.

j This assumes that staff to resident ratios are consistent across younger and older adult homes.

k This assumes that direct care workers attend training according to the mode of delivery proportions. If, for example, more than 13% of trained direct care workers took e-learning training courses, this would lower the national cost estimate of current costs.

The national costs presented are static (i.e. point in time), providing estimates for how much it would cost to train staff currently employed (those already trained and training all staff). Training costs will also have a dynamic element given staff turnover, and particularly so in adult social care where there are high levels of turnover and job vacancy rates[13]. As an indication of this dynamic cost, we estimate the one-year cost gap for training all new staff from outside adult social care (i.e., not already trained) using best practice training compared to if they were trained to current levels. In 2025, the new starter rate for care workers was estimated at 35.1%, with 46% of these new starters recruited from outside adult social care[13]. Using the estimate of FTE staff working with older adults, this suggests that there were 135,917 new starters from outside adult social care. Taken together with per FTE staff member working with older adults cost of adapting to best practice training (£67.71) would give a one-year total cost gap to train new starters using best practice of £9.2m.

The cost gap between the cost of current levels of training and cost of best practice (i.e. eight hours of in-person training) for all qualified staff is estimated as £57m (£39.0m total staff cost and £18.0m total training delivery cost) for England. **Adopting best practice training for the older adult care workforce would be at an estimated cost of £57m, or £67.71 per FTE staff member working with older adults. If the cost to train new starters is also included (£9.2m) this is a total of £63.2m.** Given that in our audit, nearly 40% were developing training in house and meeting the associated costs, and of the providers paying for external training 66% were meeting the costs, it will likely be challenging for providers alone to fund this shortfall.

THE TRAINING GAP: A HIDDEN INJUSTICE IN DEMENTIA CARE AND HOW TO FIX IT
POLICY RECOMMENDATIONS

The case for change is undeniable - swift action can, and must, be taken to better equip the social care workforce with the right level of skills to consistently deliver quality, personalised dementia specific care. Moving from awareness to understanding is more important than ever before with rising dementia prevalence and increasing social care utilisation[l].

National governments, commissioners, regulators and providers all have a vital role to play in bridging the dementia training gap, building a more resilient and compassionate social care workforce that is ready to rise to the challenge of caring for people living with dementia.

THERE ARE A NUMBER OF AREAS WHERE THE CURRENT DEMENTIA TRAINING OFFER ACROSS THE SOCIAL CARE SECTOR IS NOT ALIGNED TO BEST PRACTICE STANDARDS:

- Over half of the training described in the audit was Tier 1 awareness-level only. Direct care staff, who support people with dementia daily, are not routinely receiving higher-level Tier 2 training that is dementia specific.
- There is limited coaching, mentoring or supervision, only about 13% of training packages includes peer support, mentoring or reflective learning, which are core elements of good practice.
- Training is heavily reliant on e-learning (around half of all training is delivered in this way), with 71% of e-learning only being delivered at an awareness level.
- Training is too short to have sufficient impact for learning, most often 1-2 hours, falling significantly below the recommended 8-hour threshold.
- Just over half of the training reported was evidence based, with providers struggling to cite the evidence underpinning training.
- Few providers use recognised frameworks, such as the Dementia Training Standards Framework in England.
- Whilst digital learning was not widely perceived as a barrier by most providers or staff, there was a clear mismatch between how training is delivered and how it is supported. While half of training is delivered online, home care providers rarely supply devices, cover costs, or provide digital support.

Despite these issues, our findings describe a workforce that is positive and willing, with just over 80% of staff respondents wanting more dementia specific training. The training staff are getting is not preparing them effectively, and our findings illustrated that there are lower than expected levels of knowledge and confidence – further demonstrating that the generic, awareness level training that most staff are getting is not meeting their development needs.

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l alzheimers.org.uk/sites/default/files/2024-05/the-annual-costs-of-dementia.pdf

With the right support and guidance, the provision of the right dementia training for the social care workforce offers a very significant opportunity to improve the standards of care for people living with dementia. Doing so would improve people's quality of life and also lead to significant additional benefits for people with dementia, their unpaid carers, care homes and the wider sector, including reduced hospital admissions, GP appointments and lower staff turnover[3].

To meet these aims, we call on national and local government, local authorities, regulators and providers to take action on the following recommendations:

OVERARCHING RECOMMENDATION

A legal requirement for all social care providers to ensure all direct care staff working in older adults' care – and direct care staff working with people living with dementia in other settings – undertake best practice dementia training. This should include both home care and care home staff.

CARE QUALITY COMMISSION

This should be given effect through CQC statutory guidance on dementia, with a requirement for staff to undertake best practice dementia training of at least eight hours, mapped to at least Tier 2 of the Dementia Training Standards Framework and with delivery meeting the five key components of best practice training (evidence-informed training design; effective delivery method; inclusive digital learning; support and accessibility; and strong leadership to foster long-term impact of training). The guidance should make clear that this is necessary to comply with Regulation 18.

EVIDENCE OF COMPLIANCE WITH REGULATION 18 SHOULD INCLUDE:

- Training has been evaluated and has impacted on staff knowledge, confidence and attitudes to dementia and care practice.
- Training has been mapped to the Dementia Training Standards Framework and is at least Tier 2 for all direct care staff working in older adults' care.
- Training has been designed to meet the specific needs of the learners (using a tool such as a Training Needs Analysis tool).
- Training is evidence based - underpinned by evidence and that the provider is familiar with the evidence underlying the training.
- Training represents the full diversity of lived experience of people with dementia, unpaid carers and staff.
- Includes in-person training and/or interactive online training, mentoring and/or coaching.
- Training includes at least eight hours dementia specific training in delivery.
- Where care providers are found to not meet the above requirements for good quality dementia care, the CQC must set out clear improvement measures and use its existing powers where necessary to drive improvement.

UK GOVERNMENT

- The UK government should consider how to support providers to meet the new proposed requirement in the CQC statutory guidance. Levelling up from the
- current average training care workers receive to best practice training would be at an estimated cost of £67.71 per person, or a total of £57m. This includes the cost of training (£18m) and staff time (£39m). There would be an approximate additional annual cost of £9.2m to train new starters.
- The UK government should ensure that the Care Workforce Pathway accurately reflects the importance of best practice dementia training for all direct care staff in older adults' care and for direct care staff working with people living with dementia in other settings.

SKILLS FOR CARE AND EXECUTIVE OVERSIGHT GROUP MEMBERS

- Skills for Care and relevant members of the Workforce Strategy Executive Oversight Group should take action to raise awareness among local authorities and care providers of the Dementia Training Standards Framework, and in particular to raise awareness of the importance of ensuring that dementia training for direct care staff meets Tier 2 of the Dementia Training Standards Framework.

CARE PROVIDERS, TRAINING LEADS AND STAFF

Providers should ensure that dementia training for direct care staff is:

- Aligned to Tier 2 of the Dementia Training Standards Framework.
- Designed to meet the specific needs of the learners (using a tool such as a Training Needs Analysis tool).
- Evidence based – underpinned by evidence and that the provider is familiar with the evidence underlying the training.
- Representative of the full diversity of lived experience of people with dementia, unpaid carers and staff.
- Includes in-person training and/or interactive online training, mentoring and/or coaching.
- At least eight hours in delivery.
- Inclusive of an evaluation component to assess good quality training.

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APPENDIX A: GLOSSARY

Blended learning delivery	A form of training delivery that uses a combined approach with both online and face-to-face methods, such as attending some in-person sessions, followed up with online exercises and discussion groups.
(The) Care Certificate (TCC)	An induction framework in England for all staff working across health and social care settings. It is not dementia specific, but designed to equip workers with introductory skills and knowledge for basic care.
Care homes	Homes and settings that provide both accommodation and care for people unable to live independently.
Dementia Care Mapping (DCM)	A formal observation tool (requiring formal training) for use in dementia care to evaluate, reflect on and improve person-centred care.
Dementia champion	A staff member who has received dementia specific training and who undertakes a leadership role for dementia care within the setting. This might include providing mentorship to other staff, encouraging uptake of dementia training and encouraging and supporting best practice in dementia care.
E-learning	A form of training delivery that uses only computer-based content to be completed independently by learners, without the input of "live" interaction with facilitators or other learners.
Evidence-based practice	Practice that is guided by an understanding of what is demonstrated to work best in particular circumstances (as opposed to habit or guesswork). Evidence is gained through a systematic approach to evaluating activity (such as research).
Face-to-face delivery	Training delivery that occurs in-person, with a group of learners and one or two facilitators.
Home care	Formal care that is provided in a person's own home, in the form of scheduled visits. Can be known as domiciliary care.
Mentoring	A relationship between two people with the aim of professional development. The mentor is usually an experienced person who shares experiences, skills and advice with a less-experienced person.
Training	A formal method to enable learning that uses expert input (via a teacher, trainer or facilitator) to develop people's skills and understanding of a particular topic//task. It most commonly relates to a specific role and has a focus on application of knowledge to practice.
Training Needs Analysis (TNA)	A review of learning and development requirements in an organisation or setting based on an assessment of what skills are needed, what skills presently exist and what skills are lacking. Ideally it would take place at an organisational, team and individual level.

APPENDIX B: FOR PROVIDERS, COMMISSIONERS AND TRAINING LEADS

RESOURCES FOR DEVELOPING, DELIVERING AND EVALUATING TRAINING

The following components of good practice should be considered by providers, commissioners or training leads in the development, delivery and evaluation of training. Best practice training has these components of good practice:

- Training has been evaluated and has impacted on staff knowledge, confidence and attitudes to dementia and care practice (see supplementary materials for guidance on measuring training impact).
- Training has been mapped to the Dementia Training Standards Framework, and is at least Tier 2 for all direct care staff working in older adult's care.
- Training has been designed to meet the specific needs of the learners (using a tool such as a Training Needs Analysis tool).
- Training is evidence based - underpinned by evidence and that the provider is familiar with the evidence underlying the training.
- Training represents the full diversity of lived experience of people with dementia, unpaid carers and staff.
- Training includes in-person training, mentoring and/or coaching.
- Training includes at least 8-hours dementia specific training in delivery.

Further advice about how to develop and deliver training in line with these components of good practice can be found in the Dementia Training Design and Delivery Audit Tool (DeDAT tool). The DeDAT tool has been used to inform the advice presented in this section, but is not presented in full and has been adapted to align with the recommendations of this report. The full DeDAT tool provides additional information about best practice related to specific delivery models. We recommended that the DeDAT tool in full is referred to for evidencing best practice implementation of training by regulators and commissioners.

The DeDAT audit manual is available here
https://www.leedsbeckett.ac.uk/research/centre-for-dementia-research/what-works/

The following table summarises the standards of best practice training should align to, per the recommendations of this report, and how to providers might achieve and evidence these standards for commissioners or regulators, such as the CQC.

STANDARD	DESCRIPTION	RECOMMENDATIONS / RESOURCES / HOW TO EVIDENCE THIS
Design content and materials		
Training maps onto the intended, relevant Dementia Training Standards and is at Tier 2 for direct care staff – with clear learning objectives/ outcomes associated with the subject and Tier.	Learning outcomes are a measure of achievement of learning and reflect what a learner should know or be able to do at the end of completing a session or programme of learning. They should therefore be demonstrable, measurable or testable. The Dementia Training Standards Framework includes a set of learning outcomes associated with each subject area. A single training programme should not aim to cover all subjects and all learning outcomes . The individual subjects, or some learning outcomes associated with a subject area may not be relevant for all staff roles/groups. Therefore, we recommend a training needs analysis is conducted to ensure learning outcomes are mapped appropriately to staff roles and needs. The DeTDAT tool includes an Excel based mapping tool that can help trainers, commissioners and managers to map which learning outcomes are covered within single and across multiple dementia training programmes offered within an organisation. This can help to identify overlap and gaps. The tool can be downloaded from the What Works study web-site https://www.leedsbeckett.ac.uk/research/centre-for-dementia-research/what-works/.	Resources include The Dementia Training Standards Framework. The DeTDAT audit tool. Mapping tools should be used to evidence how training content relates to the Dementia Training Standards Framework. Learning outcomes that relate to the subjects and frameworks should also be included in the learning materials.
Training has been designed for/ tailored to the specific service setting and job role of learners who will attend.	Training content and associated materials should be tailored to the service setting and role of the staff attending. If staff perceive the training is relevant to their role and the realities of day-to-day practice, they are more likely to be able and willing to implement it. The accessibility of training design and delivery should be considered, including the content, language and delivery methods, particularly if attendees may have low literacy skills, or English as a second or additional language. Training should not be generic or adopt a one- size-fits-all approach.	It is recommended to have specific training for direct care roles. Resources include Training Needs Analysis tools for dementia. Assessments of knowledge to understand levels of knowledge in staff. Collating feedback from staff / consultation with staff. Any information about staff knowledge or staff consultation should be retained as evidence (for regulators or commissioners) that training needs were assessed before the training was developed or delivered.
Training content covers all learning outcomes in a depth that is relevant to the Tier and learners' job roles.	In addition to which learning outcomes are covered, the depth of coverage is also important. Staff should have the opportunity, to cover all of the learning outcomes relevant to their role, in the required depth /at the required Tier. A brief mention of a topic, for example through inclusion via 1-2 bullet points on a slide, is likely to be insufficient to meet the depth and complexity of knowledge required to meet most of the learning outcomes in the Dementia Training Standards Framework.	Mapping exercises should consider the depth of training as well as the content.

STANDARD	DESCRIPTION	RECOMMENDATIONS / RESOURCES / HOW TO EVIDENCE THIS
Training includes interactive learning activities.	Training should be interactive, which might for example include discussion, group work, practical activities, experiential exercises, simulation, viewing videos, talks by carers and people with dementia, multi-media online content. This can support problem-solving and application of learning into practice. Predominantly didactic (talking to/at a group) training is unsatisfactory. Short periods of didactic content, within interactive learning is more appropriate. Individual learning via a written (paper or web-based) resource is ineffective for learning.	Training should include in-person elements to best meet these standard. If delivered online this should be interactive and facilitated by an experienced trainer.
Training includes group discussion.	Group discussion should be a core component of every training programme, since it aids learners to assimilate new information and to e work through complexities, ask questions and to discuss potential information barriers.	Training should include in-person elements to best meet this standard. If delivered online this should be interactive and facilitated by an experienced trainer.
Training is evidence based and the provider is familiar with the evidence underlying the training.	Training should provide evidence based and rooted in a clear and established approach that is supported by evidence. For example, the Dementia Training Standards Framework is rooted in an evidence-based approach. It may draw on established theoretical approaches that have been recognised as supporting the delivery of good quality person centred care, such as biopsychosocial approaches or person centred care.	Providers should have knowledge of the evidence that underpins the training and be able to provide information about this to regulators or commissioners.
Training represents the full diversity of lived experience of people with dementia, unpaid carers and staff.	Training should present the experience of living with dementia as a mechanism for learning. This can include talks/discussions led by people living with or supporting someone with dementia, or through presenting this using video, vignettes or case study scenarios. These should reflect the diversity of people with lived experience of dementia and of staff who support them.	Providers should be able to provide information about how lived experience is included in the training – with documentation to support this e.g. learning materials.
Training includes learning activities that involve the application of what is learnt to practice-based situation sessions.	Training should include opportunities to apply learning in practice for example through training-based exercises, simulation, role play or in-practice activities that staff carry out between training.	Training should include in-person elements to best meet this standard.
Training materials are clear and easy to follow e.g. are jargon free, clearly laid out, take into account educational background of learners.	Materials need to be accessible, jargon free and written with their audience in mind, including considering the prior educational experience, English language competency/confidence, and literacy levels of learners.	This should be able to evidence in their learning materials for regulators and commissioners.

STANDARD	DESCRIPTION	RECOMMENDATIONS / RESOURCES / HOW TO EVIDENCE THIS
Length		
Training is at least 8 hours.	More in-depth training on a topic, that is longer in overall duration (8-12 hours), is more likely to be impactful in supporting translation of learning into practice. Shorter training (less than 3.5 hours in total on a topic) is less likely to lead to improved knowledge or practice. A training programme could be delivered as multiple sessions over a number of weeks. However, individual training sessions of less than two-hours (even if combined to create a longer programme), are unlikely to be as effective.	This should be evidenced in a detailed a training plan that can be provided as as evidence for regulators and commissioners.
Facilitator		
Facilitator is experienced in the delivery/facilitation of training.	Training should be delivered by a skilled and experienced training facilitator. They should have good knowledge of the topic and be able to speak credibly about application into day-to-day dementia care practice. Skilled facilitators create a supportive and safe learning environment where staff feel comfortable to ask questions and can adapt the training content and delivery appropriately to meet the group's needs, whilst also ensuring core content delivery.	Providers should be able to provide further information on or evidence the experience and skills of the facilitators.
Evaluation		
Training has been evaluated for its acceptability/usefulness, and impact on staff knowledge, confidence and attitudes to dementia and care practice.	All training should be appropriately evaluated for its perceived acceptability/usefulness, and impact on learners' knowledge, skills, attitudes to people with dementia. Ideally evaluation should also include consideration of impact on learners' practice and on outcomes for people with dementia. However, we recognise these latter outcomes can be more challenging to evidence.	All training should be evaluated for its immediate impact on learners, providers should attempt to capture the impact of training on staff knowledge and skills, it is excellent practice to attempt to capture the impact of training on care practice (behaviour and results), through using methods such as observation (e.g. the PORT tool or Dementia Care Mapping).

APPENDIX C: FOR COMMISSIONS AND REGULATORS

RESOURCES FOR EVALUATING THE QUALITY OF DEMENTIA TRAINING

The following components of good practice should be considered by providers, commissioners or training leads in the development, delivery and evaluation of training. Best practice training has the following components of good practice:

- Training has been evaluated and has impacted on staff knowledge, confidence and attitudes to dementia and care practice (see supplementary materials for guidance on measuring training impact).
- Training has been mapped to the Dementia Training Standards Framework, and is at least Tier 2 for all direct care staff working in older adults' care.
- Training has been designed to meet the specific needs of the learners (using a tool such as a Training Needs Analysis tool).
- Training is evidence based - underpinned by evidence and thar the provider is familiar with the evidence underlying the training.
- Training represents the full diversity of lived experience of people with dementia, unpaid carers and staff.
- Training includes in-person training, mentoring and/or coaching.
- Training includes at least eight hours dementia specific training in delivery.

Regulators, such as the CQC, should look for indicators of these considerations in assessing the quality of training as part of its inspection regime.

CHOOSING THE EVIDENCE TO REVIEW

Training is usually comprised of a number of different elements including the aims and learning outcomes, training plan, written materials, PowerPoint or other visual aids, audio - visual materials, exercises and activities, handouts and how these are delivered. Ideally an evaluation should include all components of the training. Experience indicates for example that what is in a teaching plan, or on PowerPoint slides might not be what is actually delivered in the training room. Therefore, observation of delivery is essential in assessing whether the intended training is what is actually received.

STANDARD	DESCRIPTION	RECOMMENDATIONS / RESOURCES / HOW TO EVIDENCE THIS
Design content and materials		
Training maps onto the intended, relevant Dementia Training Standards and is at Tier 2 for direct care staff – with clear learning objectives/ outcomes associated with the subject and Tier.	Learning outcomes are a measure of achievement of learning and reflect what a learner should know or be able to do at the end of completing a session or programme of learning. They should therefore be demonstrable, measurable or testable. The Dementia Training Standards Framework includes a set of learning outcomes associated with each subject area. A single training programme should not aim to cover all subjects and all learning outcomes. The individual subjects, or some learning outcomes associated with a subject area may not be relevant for all staff roles/groups. Therefore, we recommend a training needs analysis is conducted to ensure learning outcomes are mapped appropriately to staff roles and needs. The DeDAT tool includes an Excel based mapping tool that can help trainers, commissioners and managers to map which learning outcomes are covered within single and across multiple dementia training programmes offered within an organisation. This can help to identify overlap and gaps. The tool can be downloaded from the What Works study web-site https://www.leedsbeckett.ac.uk/research/centre-for-dementia-research/what-works/research/centre-for-dementia-research/what-works/.	Providers should be able to evidence this standard through the use of mapping tools to show how training content relates to the Dementia Training Standards Framework. The DeDAT audit tool is one example. Learning outcomes that relate to the subjects and frameworks should also be included in the learning materials.
Training has been designed for/ tailored to the specific service setting and job role of learners who will attend.	Training content and associated materials should be tailored to the service setting and role of the staff attending. If staff perceive the training is relevant to their role and the realities of day-to-day practice, they are more likely to be able and willing to implement it. The accessibility of training design and delivery should be considered, including the content, language and delivery methods, particularly if attendees may have low literacy skills, or English as a second or additional language. Training should not be generic or adopt a one-size-fits-all approach.	Regulators should look for evidence of specific training for direct care roles. Providers should be able to evidence that a Training Needs Analysis has taken place, using tools such as assessments of knowledge to understand levels of knowledge in staff. Collating feedback from staff /consultation with staff Any information about staff knowledge or staff consultation should have been retained as evidence (for regulators or commissioners) that training needs were assessed before the training was developed or delivered.
Training content covers all learning outcomes in a depth that is relevant to the Tier and learners' job roles.	In addition to which learning outcomes are covered, the depth of coverage is also important. Staff should have the opportunity, to cover all of the learning outcomes relevant to their role, in the required depth /at the required Tier. A brief mention of a topic, for example through inclusion via 1-2 bullet points on a slide, is likely to be insufficient to meet the depth and complexity of knowledge required to meet most of the learning outcomes in the Dementia Training Standards Framework.	Providers should provide evidence of the depth of training through b mapping exercises and learning outcomes included in the learning materials.

STANDARD	DESCRIPTION	RECOMMENDATIONS / RESOURCES / HOW TO EVIDENCE THIS
Training includes interactive learning activities.	Training should be interactive, which might for example include discussion, group work, practical activities, experiential exercises, simulation, viewing videos, talks by carers and people with dementia, multi-media online content. This can support problem-solving and application of learning into practice. Predominantly didactic (talking to/ at a group) training is unsatisfactory. Short periods of didactic content, within interactive learning is more appropriate. Individual learning via a written (paper or web-based) resource is ineffective for learning.	Providers should be able to show how the training is interactive through the learning materials or observations of training. If delivered online providers should make clear how the interactive element is being met.
Training includes group discussion.	Group discussion should be a core component of every training programme, since it aids learners to assimilate new information and to e work through complexities, ask questions and to discuss potential information barriers.	Providers should be able to show how the training is interactive through the learning materials or observations of training. If delivered online providers should make clear how the interactive discission opportunities are provided.
Training is evidence based and the provider is familiar with the evidence underlying the training.	Training should provide evidence based and rooted in a clear and established approach that is supported by evidence. For example, the Dementia Training Standards Framework is rooted in an evidence-based approach. It may draw on established theoretical approaches that have been recognised as supporting the delivery of good quality person centred cares, such as biopsychosocial approaches or person-centred care.	Providers should have knowledge of the evidence that underpins the training and be able to provide information about this to regulators or commissioners.
Training represents the full diversity of lived experience of people with dementia, unpaid carers and staff.	Training should present the experience of living with dementia as a mechanism for learning. This can include talks/discussions led by people living with or supporting someone with dementia, or through presenting this using video, vignettes or case study scenarios. These should reflect the diversity of people with lived experience of dementia and of staff who support them.	Providers should be able to point to where on the learning materials of learning plan provide information about how lived experience is included in the training – with documentation to support this.
Training includes learning activities that involve the application of what is learnt in a practice-based situation.	Training should include opportunities to apply learning in practice for example through training-based exercises, simulation, role play or in-practice activities that staff carry out between training sessions.	Training should include in-person elements to best meet this standard. If using e-learning careful consideration should be given to how to entact this kind of practice based training sensitively and ethically. This should be evidenced in the learning materials and plan, or by observation.
Training materials are clear and easy to follow e.g. are jargon free, clearly laid out, take into account educational background of learners.	Materials need to be accessible, jargon free and written with their audience in mind, including considering the prior educational experience, English language competency/confidence, and literacy levels of learners.	Providers should be able to evidence this in their learning materials for regulators and commissioners.

STANDARD	DESCRIPTION	RECOMMENDATIONS / RESOURCES / HOW TO EVIDENCE THIS
Length		
Training is at least 8 hours.	More in-depth training on a topic, that is longer in overall duration (8-12 hours), is more likely to be impactful in supporting translation of learning into practice. Shorter training (less than 3.5 hours in total on a topic) is less likely to lead to improved knowledge or practice. A training programme could be delivered as multiple sessions over a number of weeks. However, individual training sessions of less than two-hours (even if combined to create a longer programme), are unlikely to be as effective.	This should be detailed in a training plan as evidence for regulators and commissioners.
Facilitator		
Facilitator is experienced in the delivery/facilitation of training.	Training should be delivered by a skilled and experienced training facilitator. They should have good knowledge of the topic and be able to speak credibly about application into day-to-day dementia care practice. Skilled facilitators create a supportive and safe learning environment where staff feel comfortable to ask questions and can adapt the training content and delivery appropriately to meet the group's needs, whilst also ensuring core content delivery.	Providers should be able to provide further information on or evidence the experience and skills of the facilitators.
Evaluation		
Training has been evaluated for its acceptability/usefulness, and impact on staff knowledge, confidence and attitudes to dementia and care practice.	All training should be appropriately evaluated for its perceived acceptability/usefulness, and impact on learners' knowledge, skills, attitudes to people with dementia. Ideally evaluation should also include consideration of impact on learners' practice and on outcomes for people with dementia. However, we recognise these latter outcomes can be more challenging to evidence.	All training should be evaluated for its immediate impact on learners, providers should attempt to capture the impact of training on staff knowledge and skills, it is excellent practice to attempt to capture the impact of training on care practice (behaviour and results), through using methods such as observation (e.g. the PORT tool or Dementia Care Mapping).

APPENDIX D: DETAILED COSTINGS

Estimates as to the current costs of training a care worker in England were based on data from the response providers gave across all three countries that completed the audit, i.e. England, Northern Ireland and Wales. The average cost of dementia training per staff member was estimated by mode of delivery separately, i.e., e-learning, internal or external within countries. Whilst all training packages were used to estimate the average dementia training time per course and number of course participants which determine the estimates for costs.

COST PER STAFF MEMBER

For each type of training course *i* in country *j*, the cost per staff member (C_{ij}) is estimated as:

$$C_{ij} = s_j + d_i$$

Where s_j is the individual staff cost of attending training in country *j* and d_i is the per staff member cost of training course delivery for mode *i*. The cost of paying a member of staff whilst they are in training is calculated as their numbers of hours in training *(h)* multiplied by their hourly pay rate (w_j), i.e. $s = h.w_j$. Average number of hours of training is estimated from the survey data as 4.96 hours (95% confidence interval: 3.67-6.26 hours). The costs for training that was 1-2 hours (most common duration of training) and training lasting 8 hours (best practice standard) was also calculated. For pay, the hourly pay rate for England was taken as the national average hourly pay rate for care workers (£12.18) in independent providers (Skills for Care, 2025).

For cost of the training course, d_i, the cost for an external course is estimated from the reported external costs in the survey data. Average cost per external course is estimated as £1,864.14 (95% confidence interval: £495.20-£3233.10).

For internal courses, the course cost per staff member was assumed to be the sum of *development costs, cost of trainer, preparation costs, cost of room hire, IT costs, equipment costs and other costs.* Data reported for in-house courses in the sample were used to estimate these costs. From the survey data, *room hire, equipment, IT* and *other* costs were all assumed zero where there was non-response to each respective question. In estimating total internal training course cost, *room hire, IT, equipment* and *other* costs were assumed to be zero as the sample data did not provide evidence of the costs being significantly different from zero.[1]

Development costs were estimated from the average development time reported in the survey (55.6hrs) multiplied by the hourly wage of those that developed it. Without knowledge of whom developed the training, we used the registered nurse hourly wage (£21.47) in England from Skills for Care (2025) to get an (average) total development cost of £1,193.60. When looking at the cost of development of an individual training session,

1 Any IT costs and equipment costs for training courses could be seen as indication of more specialised training or that providers could gain further benefit from these cost outlays. For other costs, responses indicated costs that were supplemental to training, such as food and drink, or could lead to double counting, such as staff backfill.

this (fixed) cost of development depends on how many sessions of the internally developed course have been delivered. From the survey data, the average course had been delivered 258.3 times (95% confidence interval: 55.8-460.9). This gave an average *development cost* per session of £4.62.

In terms of *preparation costs*, there was assumed to be a one-hour preparation time for the trainer where there was non-response to this question in the survey. Average *preparation costs* were estimated as £34.11 (95% confidence interval: £10.70-£57.50). Where cost of trainer was not reported in the survey data, this was instead calculated as being equal to the average course length (4.96hrs) multiplied by the trainer wage. Taking information from some of the audit data on whom delivered the training, the trainer hourly wage is calculated as a weighted average of the hourly pay of registered manager/ deputy manager (for specialist trainers), registered nurse (for clinical/other) and senior care worker (for dementia champions) from England using national data from Skills for Care (2025).[2] This gave an average hourly wage of the trainer of £17.65. Average cost of training delivery was then estimated as £116.76 (95% confidence interval: £90.78-142.74). Overall, the average internal training course cost per session was £155.49.

For e-learning, the course cost per session is assumed to be equivalent to the average development cost of all training courses, which was estimated in the same manner as described for internal courses but using data on average number of sessions delivered from all courses. This gave an estimated average course cost per session of £3.91.

AVERAGE COST OF DEMENTIA TRAINING

From the audit data it was also possible to estimate the cost of dementia training per staff member that attend the average dementia training course. From the audit data, it was estimated that the average (in-person) training course had 11.84 members of staff attending (95% confidence interval: 10.48-13.21). We divided course delivery costs per staff member attending. For the average training course overall, i.e. weighted by mode of delivery, we used audit data on the prevalence of training courses available by delivery mode to weight cost of course per staff member by type of training course. From the survey data, 13% of courses were e-learning, 38% were delivered in-person by external companies and 49% were delivered in-person by internal members of staff. Overall average cost per staff member is the weighted average of all three modes of training course delivery. In-person average cost per staff member is calculated as the weighted average of external (44% of all in-person courses) and internal (56%) training courses. Note that we did not include any additional costs of staff cover to support colleagues to attend the training during their usual shifts, rather than to attend paid training programmes on scheduled days off. We recognise that this is a cost incurred by some but not all providers.

To estimate current costs of dementia training to the sector at a national level, estimates were required on the number of staff trained. Data from the audit suggested that the average training course in the sample had been completed by 77% of direct care staff.

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2 Hourly pay of registered managers and deputy managers were estimated from average annual salary using a 37-hours working week. We assumed an even split in training delivery by the two manager types in generating the hourly wage for specialist trainers.

We then multiplied estimates of the total direct care workforce in each country by this estimate of proportion trained, assuming it was constant across countries. For England, total direct care staff was the total number of FTE direct care staff as per national estimates from Skills for Care (2025), this is 915,000.

For best practice national cost estimates, we further assumed that a certain proportion of staff will be working in ASC for younger adults and will not require dementia training.[3] We estimated this to be equal to 8% of staff from Department of Health and Social Care (2025) data on number of residents in younger and older adult care homes, respectively.[4]

We multiplied the estimated number of staff that have been trained or requiring training (for best practice) by the relevant per staff member cost. For current training, this was the overall average cost of training, weighted by the proportion of training available in the three delivery modes.[5] For best practice, this was the in-person average cost of training for an 8-hour course, weighted by internal and external delivery mode.

3 This may then exclude from calculations any ASC direct care workforce who support those with early onset dementia. We assumed this to be negligible in terms of national cost calculations.

4 This assumes that staff to resident ratios are consistent across younger and older adult homes.

5 This assumes that direct care workers attend training according to the mode of delivery proportions. If, for example, more than 13% of trained direct care workers took e-learning training courses, this would lower the national cost estimate of current costs.

APPENDIX E: DATA TABLES

This appendix contains four data tables referenced throughout the report. **Table 1** maps coverage of training packages against the Dementia Training Standards Framework. **Table 2** records the level at which social care staff have received dementia training. **Tables 3 & 4** document barriers and facilitators to training delivery as reported by providers (n=53).

TABLE 1

Topics & learning outcomes of the Dementia Training Standards Framework covered by each training package

119 training packages reviewed: 97 dementia specific · 22 with a dementia component. Percentages reflect proportion of packages within each group covering the topic.

TOPIC	TOTAL N=119	%	DIMENTIA SPECIFIC N=97	%	WITH DEMENTIA COMPONENT N=22	%
TIER 1 **AWARENESS**						
Dementia awareness	**103**	87%	**85**	88%	18	82%
TIER 2 **CORE SKILLS**						
Person-centred dementia care	**95**	80%	**78**	80%	17	77%
Communication, interaction and behaviour in dementia care	**95**	80%	**80**	82%	15	68%
Living well with dementia and promoting independence	**80**	67%	**65**	67%	15	68%
Health and well-being in dementia care	**70**	59%	**58**	60%	12	55%
Dementia identification, assessment and diagnosis	**61**	51%	**49**	51%	12	55%
Dementia risk reduction and prevention	**59**	50%	**47**	48%	12	55%
Families and carers as partners in dementia care	**53**	45%	**41**	42%	12	55%
Equality, diversity and inclusion in dementia care	**52**	44%	**42**	43%	10	45%
Law, ethics and safeguarding in dementia care	**38**	32%	**31**	32%	7	32%
End of life dementia care	**27**	23%	**23**	24%	4	18%
Pharmacological interventions in dementia care	**21**	18%	**19**	20%	2	9%
TIER 3 **LEADERSHIP & RESEARCH**						
Research and evidence-based practice in dementia care	**21**	18%	**19**	20%	2	9%
Leadership in transforming dementia care	**10**	8%	**7**	7%	3	14%

TABLE 2

Level at which social care staff have received dementia training

n=184 social care staff surveyed; 174 responded to this question. England only. Respondents may report multiple training routes

TRAINING ROUTE	COUNT OF 174	% OF RESPONDENTS
TOTAL RESPONDENTS	**174**	—
Dementia awareness	139	**80%**
Other dementia specific training	95	**55%**
Care Certificate (TCC)	93	**53%**
Dementia training as part of induction	82	**47%**
Dementia training as part of formal qualification (NVQ or degree)	50	**29%**
Other	12	**7%**

53
Providers surveyed (England) Tables 3 & 4

57%
Top barrier: unable to release staff from duties

64%
Top facilitator: support from management

TABLE 3

Barriers to training

% of 53 providers reporting each barrier (multi-select). Sorted by frequency.

BARRIER	N	%
Unable to release staff	30	57%
Direct costs of training	27	51%
Training outside paid hours without remuneration	13	25%
Support from management	11	21%
Have not experienced any barriers	10	19%
Language and / or cultural needs of staff	10	19%
Geography / distance to travel	9	17%
High staff turnover	9	17%
Lack of staff engagement / interest	9	17%
Access to digital devices / technology	6	11%
Staff morale / burnout	4	8%
Access to appropriate space for training	4	8%
Don't know	4	8%
Access to mentors	3	6%
Other	2	4%
Lack of suitable training	1	2%

TABLE 4

Facilitators of training

% of 53 providers reporting each barrier (multi-select). Sorted by frequency.

FACILITATOR	N	%
Support from management	34	64%
Positive staff engagement	29	55%
Skilled and experienced facilitator	23	43%
Positive cultures of care	21	40%
Group-based learning	17	32%
Access to space for training	15	28%
Renumeration for staff outside paid hours	14	26%
Designated training lead / dementia champions	14	26%
Technology	12	23%
Ring-fenced time	11	21%
Adaptability to language or cultural needs of staff	10	19%
Direct costs for training supported	9	17%
Don't know	7	13%
Staff incentives	7	13%
Protected time to reflect	6	11%
Nothing has helped	4	8%
Other	1	2%

APPENDIX F: SUMMARY OF FRAMEWORK TOPICS AND TIERS

SUBJECT (CORE TOPIC)	TIER 1 AWARENESS	TIER 2 CORE SKILLS	TIER 3 LEADERSHIP
1. Dementia awareness	✓	✓	✓
2. Dementia identification, assessment and diagnosis		✓	Partial
3. Dementia risk reduction and prevention		✓	✓
4. Person-centred dementia care		✓	✓
5. Communication, interaction and behaviour in dementia care		✓	✓
6. Health and well-being in dementia care		✓	Partial
7. Pharmacological interventions in dementia care		✓	Partial
8. Living well with dementia and promoting independence		✓	✓
9. Families and carers as partners in dementia care		✓	✓
10. Equality, diversity and inclusion in dementia care		✓	✓
11. Law, ethics and safeguarding in dementia care		✓	✓
12. End of life dementia care		✓	✓
13. Research and evidence-based practice in dementia care		✓	✓
14. Leadership in transforming dementia care		✓	✓


LBU
LEEDS
BECKETT
UNIVERSITY


Alzheimer's
Society
It will take a society to beat dementia


IFF Research