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

Northern Ireland Edition

LEEDS BECKETT UNIVERSITY

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

IFF Research

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We would like to thank the Lived Experience Involvement Group (LEIG) comprising people living with dementia and family members who draw on social care support. They have been instrumental to shaping this project and understanding the findings.

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
CWC Group
Dunluce Healthcare
Queens University Belfast
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 Northern Ireland's 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 in Northern Ireland 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 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

SIOBHAN CASEY

COMMISSIONER FOR OLDER PEOPLE FOR NORTHERN IRELAND

Supporting the social care workforce to care for people with dementia is one of the key leverages we have for helping people living with dementia to live well. We know that many people who live with dementia will, at some point in their lives, draw on social care support in the form of care being provided at home or living in a care home. People living with dementia rely on staff having had the right training to deliver care that is not only safe but enhances their well-being and quality of life.

Unfortunately, despite knowing about the benefits of training, indicators from research have suggested that not all social care staff get dementia specific training. Indeed, in Northern Ireland we do not know about the reach or extent of training for the social care workforce. This report has, at a critical time, shed light on the extent of training provided to the social care workforce, and the degree to which training that is being provided meets known benchmark standards for training or aligns to the Dementia Learning and Development Framework. One of the key findings from the research underpinning this report is that whilst staff in the social care workforce may have some training, the training often isn't dementia specific or at the right level to enable them to confidently deliver care for people with dementia. Furthermore, it is often not delivered in ways that we know to be more effective for promoting learning.

The report calls on government and regulators 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 should expect. I support this call for the government to take account of these recommendations and the investment that is required to enable providers to offer direct care staff the right training to enable them 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, national and local 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 England and Wales are available.

WHO TOOK PART?

Responses were received from 19 social care providers in Northern Ireland, reporting on 29 training packages. The survey was completed by 43 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 17% of dementia training was designed to deliver the knowledge and skills needed by social care staff who work in settings with a high proportion of people living with dementia i.e care home staff and most staff working in home care settings. Only 24% of dementia training provided foundational knowledge for staff who have contact with people with dementia or work in non specialist settings.

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 44% 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 or work in specialist settings. Compared to the care provider audit, where 93% 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 (91%) 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).

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 the Department of Health amending the minimum standards[b] for nursing care, residential care homes and domiciliary care, with a requirement for staff to undertake best practice dementia training of at least eight hours, mapped to at least Tier 2, or Tier 3 for staff working in settings with a high proportion of people with dementia, of the *Dementia Learning and Development Framework*[1] 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 Department of Health 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.

b Care Standards for Nursing Homes (December 2022), Residential Care Homes Minimum Standards (December 2022), Domiciliary Care Agencies Minimum Standards (August 2021).

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 Learning and Development Framework*[1].

The Dementia Learning and Development Framework describes 13 themes that are critical for the delivery of dementia care, with learning outcomes for each theme aligned to four training tiers based on a staff member's intended knowledge and skills: Tier 1- Introductory, which all health and social care staff should have; Tier 2 – Foundation, for staff involved in any aspect of care for people living with dementia, Tier 3 – Informed Practice for staff in contact with a high proportion of people with dementia, and Tier 4 – Advanced Practice for staff with a leadership role. Training should also meet the five key components for best practice training as outlined in the report *Because We're Human Too*[2]. These components are; covering evidence informed training design, effective delivery method, digital inclusivity, support and accessibility, and strong leadership. It should include interactive: 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[3].

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. Tier 1 of the Dementia Learning and Development Framework covers the topic of dementia awareness only. Tier 2-4 training can include awareness alongside other, more in-depth topics (e.g. Communication). 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 Learning and Development Framework, covering any of the 13 themes as standalone topics (including dementia awareness) or multiple topics. Dementia specific training is the recommended approach for the delivery of topics aligned to Tiers 2-4 of Dementia Learning and Development Framework and it is more likely to align to best practice recommendations in terms of delivery and duration of training

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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

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WHY IS BEST PRACTICE DEMENTIA TRAINING IMPORTANT IN NORTHERN IRELAND?

In Northern Ireland, there are almost 25,000 people living with dementia, a number projected to rise to around 37,400 by 2040[4]. 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]. In Northern Ireland, data from the Department of Health[6] suggests that in 2023, 12,176 care packages were being delivered in residential and nursing homes, and 80% of these (9,696) were for elderly care. Additionally in Northern Ireland an estimated 23,248 people are receiving care in their own homes.

There is a wide variation in need across individuals and the many different types of dementia that people live with[7]. People living with dementia benefit from taking part in cognitively stimulating activity, both for their wellbeing and supporting their cognitive and functional abilities[8]. 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[7]. 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[7]. 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[7]. 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 Northern Ireland. Although there is a growing body of guidance that encourages social providers to ensure their staff receive appropriate dementia training. The *'Dementia Learning and Development Framework'* (2016) was developed to support a more standardised approach to the content of dementia education, increase access to dementia training and education, and to improve its quality and consistency in standards. It outlines the knowledge and skills that health and social care staff require to deliver good dementia care, across four Tiers of expertise. The Regional Dementia Care Pathway, a model for supporting a best practice approach to dementia care across all services, is underpinned by workforce training and education. Dementia training for all staff is also recommended in the NICE Guideline on dementia[9], which is also endorsed as applicable in Northern Ireland by the Northern Ireland Department of Health.

The care workforce in Northern Ireland is also required to register with the regulatory body, the Northern Ireland Social Care Council (NISCC). Whilst there is currently no training requirement to register, staff should receive suitable induction training from their employer within the first six months of employment. The standards of conduct for social care workers set expectations around maintaining and improving knowledge and skills, including meeting the Social Care Council Post Registration Training and Learning Requirements, aligned to the job role. For social care workers this is 90 hours of continuous professional learning over the registration period of five-years, and for social workers and social care managers, 90 hours over three-years. However, dementia knowledge, skills and training are not specifically mentioned, nor the *Dementia Learning and Development Framework*[1].

From a regulatory perspective, the Minimum Standards for all social care services (i.e. residential and nursing home and domiciliary care), which govern regulatory activity by the Regulation and Quality Improvement Authority (RQIA), set expectations around identification of staff training needs and provision of suitable training to meet these needs. However, again dementia care is not specifically mentioned nor reference to the national *Dementia Learning and Development Framework* to determine training needs.

At present, we do not have data that evidences the impact of these regulatory initiatives on training practice, or have an understanding of the landscape of training provision in Northern Ireland. 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, which does provide generalisable information about training that is more likely to impact positively on person-centred care practice. This included a large-scale review of evaluated education and training programmes[10], a national audit of dementia education and training[11] and in-depth case studies within social care provider organisations[12]. 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[13,14] has 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'[2]. 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 (p26).

This 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. Since there is currently no national dataset for Northern Ireland, or research to date, detailing access to and completion of dementia training among the social care workforce, little is known about access to dementia training, the quality of this and if, and how, this prepares the Northern Ireland social care workforce to provide good person-centred care to people living with dementia.

The evidence and data in this report 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 Northern Ireland.

RESEARCH METHODOLOGY

The information underpinning this report was collected by

METHOD 01

Online Audit

19 PROVIDERS
29 PACKAGES

- 19 Care home and home care providers reporting about 29 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 Learning and Development Framework*
- Assessed against the five key components of impactful dementia training

METHOD 02

Online Survey

43 CARE STAFF

- Completed by 43 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 NORTHERN IRELAND

WHAT DEMENTIA TRAINING CARE HOME AND HOME CARE PROVIDERS ARE OFFERING IN NORTHERN IRELAND

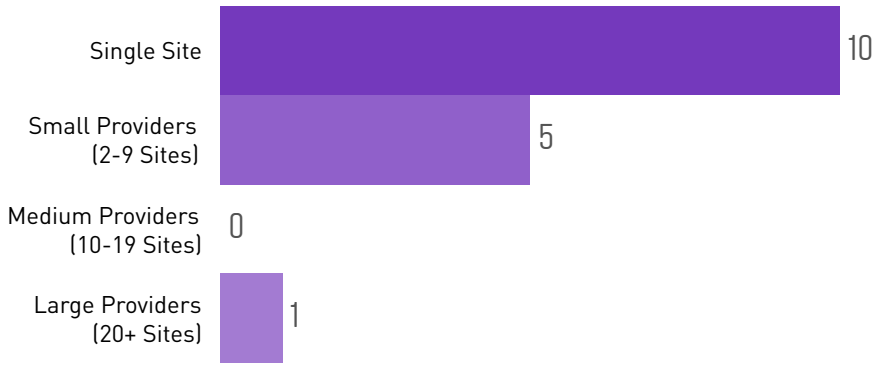
The quality of dementia training was assessed using an audit that was shared with providers with the aim of understanding the training delivered in the social care sector. A wide range of providers responded representing **29-64 care homes sites and sites with home care services**[c].

19 social care providers responded to the audit including 12 care home providers, five home care services, three described themselves as training providers, and one didn't know[d].

Of the 19 respondents, 10 of the providers represented single sites or regions (home care), five represented small providers (2-9 sites), with one large provider (20+ sites)[e]. Three respondents were local social care trusts.

FIGURE 1

Overview of the size of providers



c This is broken down as 15-50 care home sites, eight home care only and two combined sites. Data presented as a range due to response parameters in the audit.

d Multiple responses could be provided

e Large provider is multination

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 UK15. In Northern Ireland 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.

Of the 19 respondents two (11%) had 1-49 direct social care staff, six (32%) with 50-99 staff, three (16%) with 100-499 staff, one (5%) with 500+ staff and one (5%) 1000+ staff (multinational provider).

19 providers who responded gave information in the audit about **29 different training packages**. Nine providers (47%) reported about one package, with the rest reporting on multiple training packages: five providers (26%) reported two training packages, two providers (11%) reported three packages, one provider (5%) reported on five packages.

Of the 29 packages, 27 (93%) were dementia specific training and two (7%) 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). Twelve (41%) were part of a formal induction programme, and 17 (59%) were not. Frequency of delivery was explored, but for 24% of the packages this was not known, while 34% of the training packages had been delivered less than 10 times in the last 5 years.

For the 29 packages, 52% were bought in as outsourced training, 7% involved staff attending training off site with an external provider, and 34% 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 (52%) reach 76% or more of the workforce.

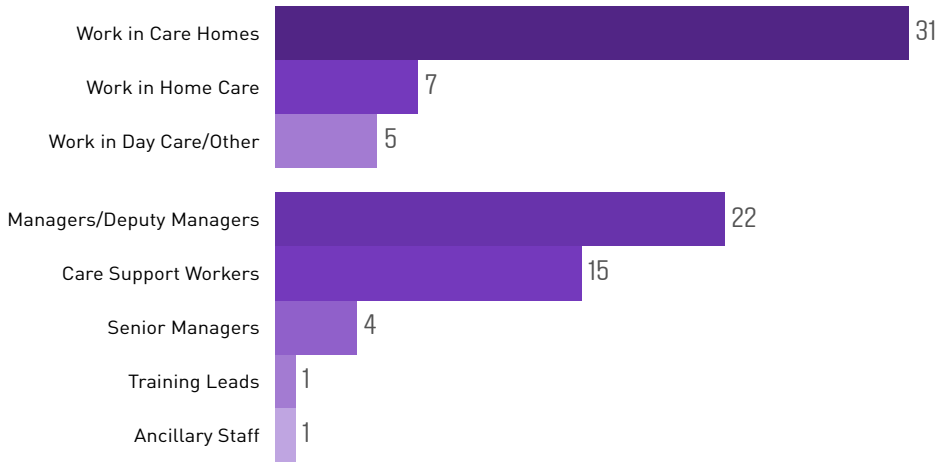
WHAT DEMENTIA TRAINING ARE THE SOCIAL CARE WORKFORCE RECEIVING IN NORTHERN IRELAND

The staff survey targeted social care staff in Northern Ireland and asked about the dementia training they had received. A total of 43 responses were received. This included 15 care support workers or senior support workers, 22 service managers or deputy managers, 26 senior management, one training lead, one ancillary staff, four senior management. Of the 43 respondents, 31 worked in the care homes and 7 in home care (two staff in day care, and three described as other).

FIGURE 2

Distribution of staff survey respondents by job role and service setting

(n= 184)



In total 86% 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 (91%) and white British or Irish (83%).

Just under half (44%) of respondents had completed dementia specific training, and up to 91% had completed any dementia training, with only 7% 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 Northern Ireland, The *Dementia Learning and Development Framework* (2016), 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 13 themes that are critical for the delivery of dementia care, with learning outcomes for each topic aligned to four training tiers based on a staff member's role and level of contact with people living with dementia:

Tier 1 - Introductory. This tier 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 - Foundation. This tier builds on the introductory level, ensuring registered and non-registered staff who are in non-dementia specific environments, or who are involved in any aspect of caring for people living with dementia, can understand and meet the needs of people with dementia.

Tier 3 - Informed Practice. This tier is aimed at staff working in specialist dementia settings who care for a high proportion of people living with dementia. Learning outcomes associated with this tier should enable staff to deliver good quality person cantered and relationship centred care.

Tier 4 - Advanced Practice. This tier is aimed at staff working at an advanced level of expertise, who act as role models or take a leadership role, driving improvements in dementia research.

Not all staff working in roles that have direct contact with people living with dementia require the same degree of knowledge across all the theme 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 Northern Ireland against the Dementia Learning and Development 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 working in older adult care access training across relevant subjects at Tier 2 and Tier 3 for staff working with a high proportion of people with dementia (i.e. care homes), 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 Learning and Development Framework and were asked to map the level and themes covered in the training against it.

KEY FINDINGS

1 **TRAINING LEVEL**

MORE THAN HALF OF ALL PACKAGES ARE AT AWARENESS LEVEL ONLY

52% of training offered was described as Tier 1, covering the topic of dementia awareness only.

2 **FALLS SHORT OF REQUIREMENT**

AWARENESS TRAINING ALONE DOES NOT MEET REQUIREMENTS

Training at dementia awareness level does not meet the requirements for social care staff in regular contact with people with dementia.

3 **STAFF PERCEPTION**

ONLY 44% ACCESSED DEMENTIA SPECIFIC TRAINING

When staff were asked about the training they recieved - 90% Staff reported receiving dementia awareness training. Only 44% described the training received dementia specific training.

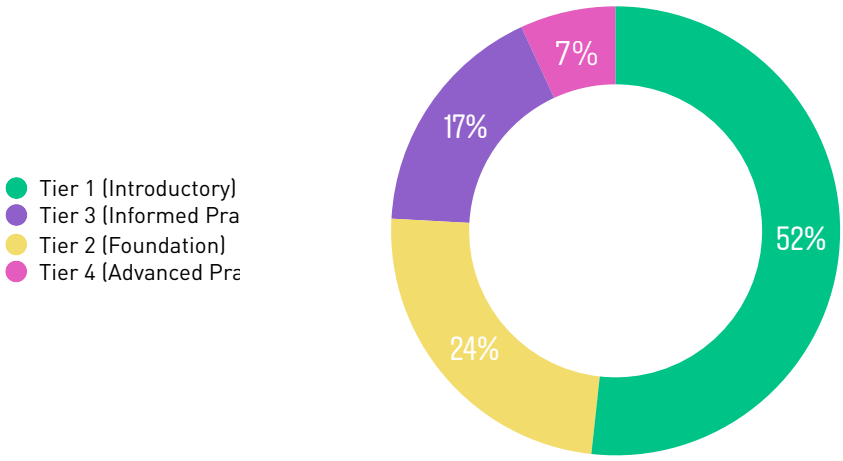
4 **INDUCTION GAP**

LESS THAN HALF OF STAFF RECEIVE DEMENTIA TRAINING AT INDUCTION

Only 36% 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

FIGURE 3

Overview of Tiers covered by training packages



TIER 1 · **INTRODUCTORY**

52% 15 packages

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

TIER 2 · **FOUNDATION**

24% 7 packages

For staff with regular contact with people living with dementia or work in non specialist settings.

TIER 3 · **INFORMED PRACTICE**

17% 5 packages

For specialist settings with high proportions of people with dementia.

TIER 4 · **ADVANCED PRACTICE**

7% 2 packages

Advanced practice and leadership in dementia care research.

SOURCE: audit of 29 training packages · Dementia Learning and Development Framework

In addition to the level of training, respondents were also asked to state which of the 13 Dementia Learning and Development Framework training themes were covered in their reported packages (see appendix F, table 1 for overview). Of the 29 packages, 28 (97%) 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.

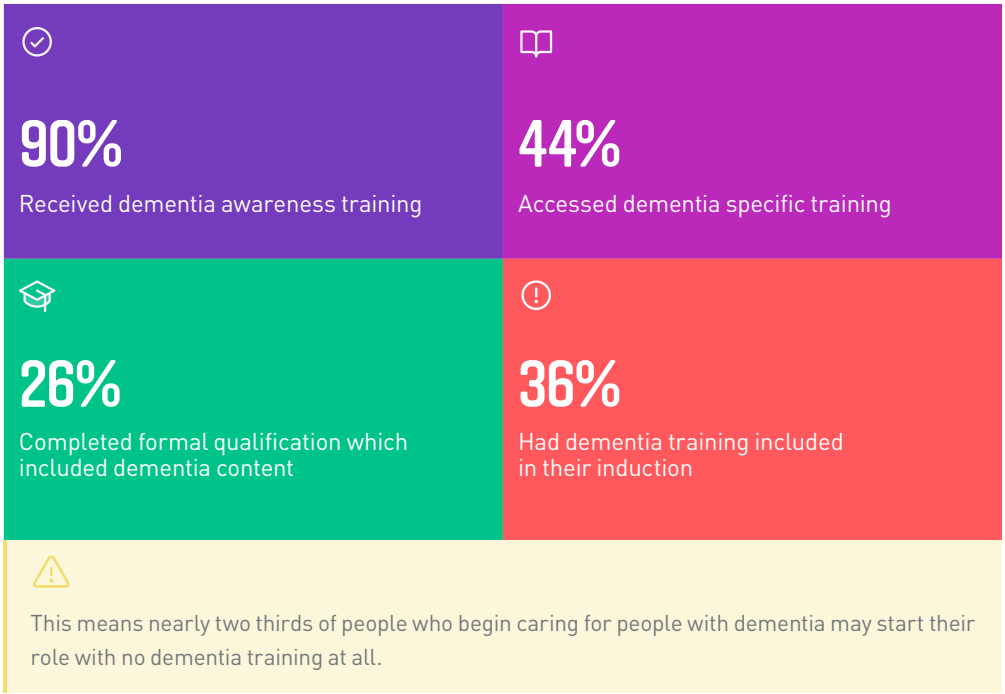
Other themes regularly covered in the packages were: communication (93%), person-centred care and relationship centred care (93%), and promoting physical, psychological and social well-being in dementia care (83%). 76% of packages included promoting enabling environments, 59% included working in partnership with families and carers, 55% included equality, cultural diversity and inclusion in dementia care.

Themes covered by 50% or less of the packages included: holistic approach to the management of dementia care (48%), legal and ethical considerations in dementia care (41%), palliative care in dementia/end of life dementia care (41%), research and evidence-based practice in dementia care (31%), receiving a diagnosis of dementia (24%), and leadership in transformational dementia care (14%). All of these themes are also critical to the delivery of social care support and play a significant role in the delivery of person-centred care. Some themes such as legal and ethical considerations in dementia care 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 90% of staff survey respondents reported that they had received dementia awareness training. In contrast, less than half (44%) had accessed dementia specific training (explored later in the section on training delivery). Only 36% 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 26% had completed a formal qualification[f], which included dementia content.

Only a third of new staff receive dementia training as part of their induction



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

ASSESSING THE DELIVERY OF DEMENTIA TRAINING

The report Because We're Human Too[2] 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 on-line 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 support learning and development. Training implementation and sustainability can be supported through dementia champions.

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

45% OF TRAINING PACKAGES WERE EVIDENCE-BASED

Most training includes views and experiences of people with dementia (34% involved people in its development).

02 — DELIVERY

AROUND HALF OF TRAINING DELIVERED BY E-LEARNING

65% of the training was of 8 hours or less duration. 48% of training is only 1-2 hours.

03 — INCLUSIVE DIGITAL APPROACH

E-LEARNING IS THE DOMINANT APPROACH TO DELIVERY

Despite e-learning being the dominant approach to delivery, only 26% providers perceived digital access as a potential barrier to training.

THERE IS A MISMATCH BETWEEN WHAT IS BEING PROVIDED AND WHAT STAFF RECEIVE

Only 44% of staff were receiving dementia specific training, but 93% of care providers are offering this

04 — ACCESSIBILITY & SUPPORT

50% 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 not offering support to access training such as translation.

05 — STRONG LEADERSHIP

MOST TRAINING PACKAGES DO NOT DEVELOP THE NEXT GENERATION OF LEADERS

Most respondents said their training packages did not support the development of staff who could support and lead implementation of good dementia care, such as dementia champions.

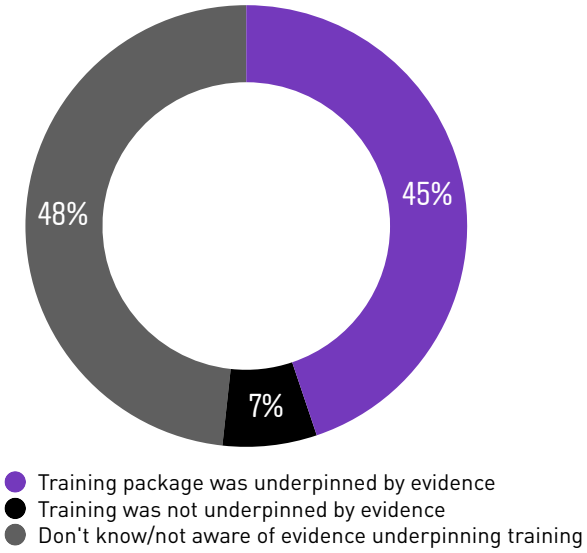
1. EVIDENCE INFORMED TRAINING DESIGN

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 Northern Ireland, the *Dementia Learning and Development Framework* 16, which is underpinned by evidence, provides a benchmarked standard against which evidence-based training can be developed or measured.

Of the 29 training packages reported in our audit, 13 (45%) said the training package was underpinned by evidence, 14 (48%) said they did not know or were not aware of the evidence that underpinned their training, and two (7%) said their training was not underpinned by evidence. These findings, that for more than half of the packages the evidence supporting them is not known or unclear, create 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 was cited for five packages (17%), two (7%) cited training standards frameworks as used. 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 Learning and Development Framework*, and of those that are, many of them are unable to expand on the evidence behind their training.

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, 26 (90%)

included examples of lived experience in the materials and 10 (34%) of packages had involved with people with lived experience in their development. While it was good to see seven (24%) 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 29 training packages, 22 (72%) said they included an assessed component, whilst 6 (21%) said they did not. Out of the 22 that included an assessed component, 21 (95%) were assessed by questions to check understanding (e.g. a quiz), three (14%) observations of practice and four (18%) discussions of case studies. 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 the training on staff had been evaluated for 13 (44%) of training packages, it had not been evaluated for 13 (44%) of training packages and whether this had been evaluated or not was unknown for three of the packages. Of the 13 training packages that had been evaluated, this most commonly took the form of informal feedback from staff (77%). 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 Tiers 2-4 of *Dementia Learning and Development 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[13].

DELIVERY OF DEMENTIA SPECIFIC TRAINING

In the 29 training packages reported in our audit, 27 (93%) were dementia specific training and 2 (7%) were more general training. Although the audit of providers showed a high proportion of dementia specific training packages (93%), 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 44% of staff were receiving dementia specific training, highlighting a contrast between what training is available from care providers as cited in the audit (93% dementia specific training) and what training is accessed by care staff.

Although 91% reported getting any dementia training, this includes dementia content within generic training, such as non-dementia specific induction training. These findings are important as they suggest that 47% 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.

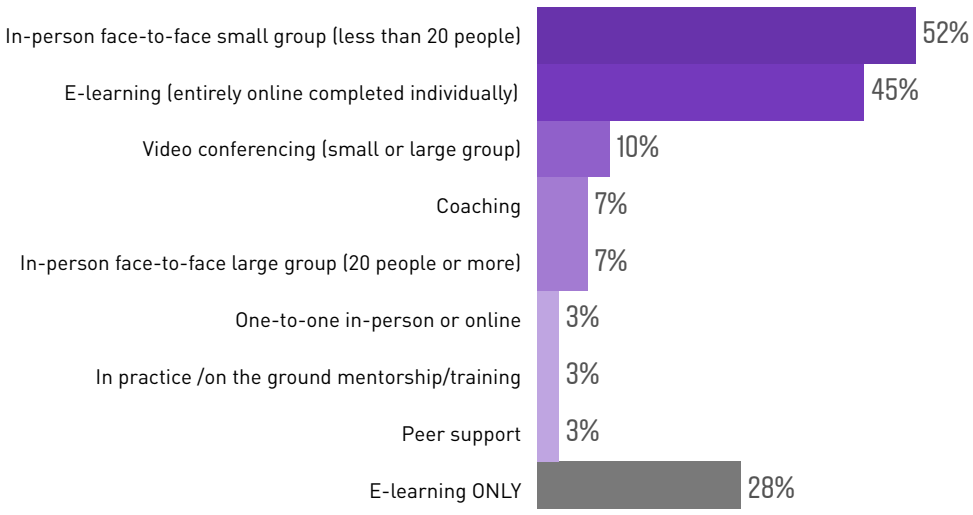
METHOD OF TRAINING DELIVERY

In our audit, around half, 13 (45%) of the 29 packages, were completed using e-learning – delivery that is computer-based without the input of "live" interaction with facilitators or other learners. Of the 13 packages reported, eight (28% 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[3].

In terms of the other delivery methods used – 15 (52%) packages were in-person, face-to-face, small group training[g] – aligning with a recommended delivery approach. Providers reported two packages (7%) used in-person face-to-face delivery in large groups, two (7%) used video conferencing, one (3%) used one-to-one in-person or online delivery, three (10%) mentoring or coaching and one (3%) peer support.

FIGURE 5

Method of training delivery



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

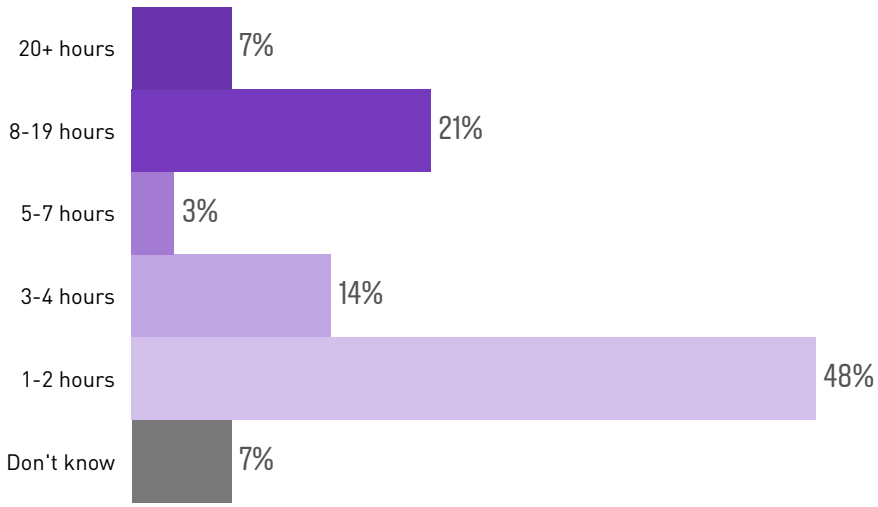
LENGTH OF TRAINING

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[17]. 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 29 training packages, 21 (72%) were standalone sessions, and eight (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. 14 (48%) packages offered 1-2 hours of dementia specific training content, four (14%) offered 3-4 hours dementia specific content, one (3%) offered 5-7 hours, six (21%) offered 8-19 hours, with two (7%) offering 20+ hours. Length was unknown for two packages. Therefore only 28% 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 88% of training delivered by e-learning lasting only 1-2 hours (seven out of eight packages). 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.

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 [18]. 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, 14 (48%) of the packages were delivered by external trainers, 10 (34%) were delivered by in-house specialist trainers, three (10%) by in-house clinical/other staff, and two (7%) by in-house dementia champions. Overall, 15 (52%) packages were delivered by in-house staff.

While over half (52%) 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 (48%) 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.

3. INCLUSIVE DIGITAL LEARNING

Despite e-learning being a frequently used method of training delivery (45%), the audit indicated access and support for technology-based learning is not being widely considered in the sector, with only five (26%) of providers 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] No respondents to this question said they provided devices to staff, none said they covered costs (e.g. wifi, purchase of equipment), however, three 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 Northern Ireland 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 29 packages, 15 (50%) were targeted to all staff groups (i.e. anyone working in the provider organisation including senior management and ancillary or administrative staff), with 12 (40%) specifically aimed at direct care staff without a professional qualification. To be accessible, 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 26 training packages. Translated materials were provided by three (12%) of the providers, and translation services were only provided by two (8%) 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, four providers said they do not offer support to access or understand training, and 10 providers said 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 did not include opportunities for the development of staff who could support and lead implementation of good dementia care, such as dementia champions. Only two of these training packages included the opportunity to train staff to be dementia champions, for both of these packages all staff were eligible to be trained as dementia champions.

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h See barriers and facilitators to training in appendix

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 [19]. 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[20]. Good quality dementia training can increase staff competency and attitudes towards dementia[21]. 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[18].

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[22-25]. In this report we explored staff knowledge and attitudes using both standardised measures of knowledge and confidence and creative approaches.

KEY FINDINGS

KNOWLEDGE

- Only 67% staff felt that had had sufficient training to enable them to care for people with dementia
- Around a third of staff do not have consistent levels of basic dementia knowledge.

ATTITUDES TO DEMENTIA

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

CONFIDENCE

Only 37% 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 91% of staff accessing any dementia training, the standardised test of knowledge that we delivered in the survey indicated that between 26%-42% 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 Assessment Scale (DKAS)[26] below.

Our survey of the social care workforce asked participants (n=43) to complete the DKAS[26] 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.

51% of respondents answered the questions around care considerations all all or majority correctly (10-12 points out of a maximum 12), and 60% answerd questions around communication and behaviour all or mostly correctly. A further 21% answered the communication and behaviour scale and 33% the care considerations scale mostly correctly (7 to 9 points). However, With 5% of staff (Communication and Behaviour Scale), and 9% of the staff (Care Considerations scale) answering 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 to low for up to 42% of social care staff.

This corresponds to previous research findings 18 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 (Tiers 2 to 4).

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.

Two thirds of staff (67%) agreed or strongly agreed that they had received sufficient dementia training to enable them to care for people with dementia, but 21% disagreed with this statement. Further, 74% strongly agreed or agreed that the training they had completed had equipped them to better care for people with dementia, whilst 19% disagreed with this sentiment.

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 74% 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 27), only 37% 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 (C&D) identified that the care Arthur received fell below the standard they would expect in their own practice.

> *Well, my thoughts about the care ... He's not Arthur anymore. They haven't asked him, would you like to get up a bit later today, Arthur? ...This man has no choice. Not at all. He is... an extension of the arm of the carer. He's been fed, he's been given food that he probably doesn't like, never ate perhaps in his life because it's on the menu. We haven't asked him what he would like, what he would need for today. Is dressing, yes, it's handier. We all say get so and so a pair of track bottoms, they're easier, I've done it myself. But we have people that have dressed, in proper trousers, proper shoes, proper socks, belts, braces, whatever. My father would have been the same. But my thought on this, this man's individuality has just been stripped bare.*
>
> (STAFF PROVIDER C CARE HOME)

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.

> *Well, me differently, I would like to sit down with Arthur and ask him anything. Heidi, would you like to help him with his jigsaw on the farm? Would you like to, oh, would you want to, what about gardening? Could we go to the garden? This man has been an outdoor person... He has, this person has been totally stripped of him. His dementia's doing it, but this care home is doing it as well.*
>
> (STAFF PROVIDER C CARE HOME)

Staff referred to the fact that it was more than just preference or good practice – there is an ethical responsibility to do more

> *Yeah, I want to say it's just common sense. Again, as the senior, it's our responsibility in terms of if somebody's lost weight that month, that is our responsibility to make sure that the carers are making sure that they are getting offered multiple options. And if they do have a sweet tooth, then make sure they're eating off the tea trolley every time and stuff like that. So I think we kind of instil it onto the carers how important it is that they are eating. If not, dietitian referral if we've tried everything else that we can.*
>
> (STAFF PROVIDER HOME CARE SITE D)

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.

> *"He should have got to know the wife more and got to know about his wee whereabouts and what he liked at home and what he liked to do, what TV he wanted to watch or if he listened to the radio. Yes. All those wee things, wee personal things. And bringing them personal things from his own home to put around him."*
> (STAFF PROVIDER CARE HOME C)

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.

Sometimes the solutions that were suggested were not reasonable or realistic, and which 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 NORTHERN IRELAND?

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[2]

CASE OVERVIEW

PROVIDER D CARE HOMES

CARE HOME GROUP · SMALL PROVIDER

PROVIDER TYPE
Residential / Nursing

TRAINING MODEL
Hybrid: e-learning + in-person

IN BRIEF
Hybrid model blending in-person sessions with accessible e-learning. Immersive role-play delivery cited as most impactful by staff. Strong informal learning culture; shadowing embedded from day one

7-8 dementia courses
posted in a single staff member's first few months — a sign of high training frequency

COMPONENTS MET

- Effective delivery
- Strong leadership

SUMMARY

This is a small provider offering a range of training opportunities, both in-person and e-learning. The offer included some in-person opportunities for engagement alongside dementia specific e-learning and other mandatory training, which evaluated well with the staff. The staff also reported on the positive informal learning culture where senior staff were approachable, and a strong ethos of providing shadowing at the point of induction – which newer staff found particularly helpful.

BACKGROUND

This care home identified as a small provider with several sites and around 400 staff. The training offer is a mix of e-learning, mandatory training and more specialist in person training provided by a local trust, which are training sessions of two to three hours.

EFFECTIVE AND INCLUSIVE DELIVERY METHOD

The staff interviews consistently cited satisfaction with the training offer and described a range of formal and informal learning opportunities available in their home.

> *There have been loads of dementia courses in the time I've been here and I've only been here since March and I think there's been about seven or eight courses being posted.*

In particular, staff provided specific feedback about the formal in-person learning opportunities delivered by the trust in house. They found this to be particularly engaging with the way in which the course was delivered (using role play), principally impactful for learning.

> *But I did feel prepared to come in here, but there's been a couple of trainings that I've had since being here that were even more helpful. I'd like to talk about those... So we did like level one and then level two dementia training. And she just like nearly took it into the mind of a person with dementia. And like acted as if she was the person with dementia and how you would, you know, what would you do in this situation and we stepped and ways to look at things and I couldn't tell you exactly what those steps were but they definitely come into play in my mind when somebody says something like, for example, what do you say when an 80 year old's looking for their mum? You know, I would always say, oh, what route do you go down with that?*

Whilst there is a clear preference on the staffs' behalf for in-person training, they did report that the e-leaning is useful, and the portal is accessible

> *Well, we can do that on our e-learning one. So we have the slideshow and the presentation that you watch, and then you do the questions on. But you can access those presentations at any time. But that's to do with the system that we use here for the training. It's quite easy structured, it's quite easy to read and to understand but again it's a wee bit surface level better than it has to be because it's for every member of staff.*

STRONG LEADERSHIP AND INFORMAL LEARNING OPPORTUNITIES

More than one staff member referred to the importance of informal learning as one of the key leverages for translating knowledge into practice:

> *I think I was quite adequately trained. In terms of your training, I think the most valuable training is actually working with the residents and like, you know, personally knowing, because even though there's loads of groups of dementia, it affects each individual so differently.*

Staff report a very positive learning environment with plenty of opportunities for formal learning but also to reflect and ask questions of senior staff

> *I think, to be honest, the training is very, very good, but I think the hands-on learning is the best way to do it. You have to just throw yourself in there and learn it yourself, obviously being given techniques and ways to help people, you need them before you start...*
> *But I would just ask anybody if there's just whoever's nearby, you know, and if they don't know, then I'll ask the senior or whoever, or the manager.*

Mentoring appears to be part of the ethos at the site:

> *Actually, whenever we first joined, there's three or four days where you're shadowing someone. So you're like watching over what they're doing and then they're basically explaining to you a lot of stuff.*

CASE OVERVIEW

PROVIDER C CARE HOMES

CARE HOME GROUP · SMALL PROVIDER

PROVIDER TYPE
Care home, small provider, 450 staff

TRAINING MODEL
Fully external, online only, dementia specific e-learning hosted by an external provider

IN BRIEF
First dementia training for many long-serving staff. E-learning only; strong staff appetite for in-person learning. Informal peer learning fills the gap.

30–60 minutes

length of dementia-specific e-learning module per staff member

COMPONENTS MET

- Evidence informed design
- Effective and inclusive digital learning
- Strong leadership

SUMMARY

This case study demonstrates the challenge for small providers in offering dementia training. Small providers are unlikely to have the resources to have internal expertise to deliver all dementia training, and in these cases external bought in provision may be higher quality. The case study shows how much staff value the training opportunities.

There was, at the same time, clear feedback from staff that in an ideal world they would prefer to have training that is in-person, and perhaps the ideal would be to combine the external training with formal leadership opportunities and informal learning opportunities.

BACKGROUND

This care home site is a small provider with around 450 staff. The training offered is dementia specific training that is e-learning, which is a relatively recent offer. Most staff completed the training within the last 6 months. For some staff interviewed who had been in caring roles for the length of their career, it was the first dementia specific training that they had undertaken. The training was part of a larger suite of online modules, and the dementia specific component lasted 30 mins to one hour, depending on how long staff took to complete. The training is provided and hosted by an external provider.

EVIDENCE INFORMED TRAINING DESIGN AND CONTENT

The training was reported as evidence based, although as it was externally bought in the provider was unable to provide details of this. The training came recommended from other care homes.

EFFECTIVE AND INCLUSIVE DELIVERY METHOD

The formal training in this case is that provided by the e-learning. Staff cited the training as useful and offering the knowledge that was required to undertake the role. All of the staff that we spoke to mentioned that they would have liked to have face to face learning opportunities too.

> *Honestly think you need to see people and talk about it. A computer, it doesn't go in. You just write, read, tick, tick. When you're actually talking to someone, and then they can have experience...and give you ideas about doing things. I honestly think it's the face-to-face they really need. It's all right on the computer. It's all right reading a book.*

Staff did feel that the e-learning was, however, really valuable for the new younger staff coming in:

> *put it this way, when we get a 16-year-old in here, that is their life. But I say, oh, I like to see that on a piece of paper. I like to see something and say, oh, you're not fully done. So that's their life. So your life is their life. So they will find that very, very instructing because that's the way they work through it. It's very personalized on that.*

In the interviews there was mention of informal opportunities that people were able to offer in more senior roles, that staff found helpful.

> *[I have had people observe] More or less training, you know what I mean, to shadow me.*
> *So say I've been doing some personal care, you know, they would just shadow me, you know what I mean, just to get in.*

STRONG LEADERSHIP AND INFORMAL LEARNING

Leadership was not explicitly mentioned by staff as a barrier or facilitator, but staff did cite a value and culture of opportunities to learn from one another, and suggested that this helped to problem solve or workshop challenges.

> *I would say it would have because there is a lot of knowledge passed through it in different ways. And to me, it's up to me how I take that. You know what I mean? You might take a certain thing different to me. You know, everyone has their own scenario or will say, well, I took it that way or I found it that way. roundabout circle gives us all when we talk about it, yeah, that's right. There's t wo ways to that.*

WHAT DOES BEST PRACTICE DEMENTIA TRAINING COST IN NORTHERN IRELAND?

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 training, too often involves 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 only, 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 Northern Ireland using data provided from our dementia training audit across all three nations (Northern Ireland, 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. We did not include any additional costs of staff cover to support colleagues to attend the training during their usual shifts, although 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 Northern Ireland 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 Northern Ireland, by training course type

TRAINING COURSE TYPE	AVERAGE TOTAL COST
e-learning	£62.83
in-person (weighted average)	£138.78
external	£219.84
internal	£75.62
OVERALL	£128.85

Average staff cost for attending training is **£62.50** in all estimates.

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.

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, with 88% of the e-learning only training being 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 £18.64 per staff member on dementia training:

TABLE 2

Estimated average cost of dementia training for 1-2hrs for a care worker in Northern Ireland, 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	£18.64
in-person (weighted average)	£90.27
external	£175.66
internal	£23.75
OVERALL	£80.91

Average staff cost for attending training is **£18.31** 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 Northern Ireland

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)	£178.15
external	£258.05
internal	£115.90

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 Northern Ireland, this was the number of people registered with the Northern Ireland Social Care Council as either an adult residential care worker or home care worker available from Northern Ireland Social Care Council (2025), this is 32,822.

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[j] on number of residents in younger and older adult care homes, respectively.[k] 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.[l] 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 **£1.6m** (£1.2–£2.0m)	CURRENT TRAINING **£1.7m**	CURRENT TRAINING **£3.3m**
BEST PRACTICE **£3.0m**	BEST PRACTICE **£2.3m**	BEST PRACTICE **£5.4m**

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 Data from Department and Health Social Care used as equivalent not available in Northern Ireland

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

l 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[14]. 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 in England was estimated at 35.1%, with 46% of these new starters recruited from outside adult social care[m14]. Using these figures, alongside the estimate of FTE staff working with older adults in Northern Ireland, this suggests that there were 4,875 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 (£69.55) would give a one-year total cost gap to train new starters using best practice of £0.34m.

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 £2.1m (£1.45m total staff cost and £0.65m total training delivery cost) for Northern Ireland. **Adopting best practice training for the older adult care workforce would be at an estimated cost of £2.1m, or £69.55 per FTE staff member working with older adults. If the cost to train new starters is also included (£0.34m) this is a total of £2.44m.**

m This data was used in lieu of NI specific data being available

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[n].

National and local 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 include 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 74% 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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n 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[2].

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.

This should be given effect through the Department of Health amending the minimum standards[o] for nursing care, residential care homes and domiciliary care, with a requirement for staff to undertake best practice dementia training of at least eight hours, mapped to at least Tier 2 or Tier 3 (as appropriate) of the Dementia Learning and Development 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).

REGULATION & QUALITY IMPROVEMENT AGENCY

Evidence of compliance with each minimum standard 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 Learning & Development Framework and is at least Tier 2 or Tier 3 (as appropriate) 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 the provider is familiar with the evidence underlying the training.

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o Care Standards for Nursing Homes (December 2022), Residential Care Homes Minimum Standards (December 2022), Domiciliary Care Agencies Minimum Standards (August 2021).

- 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 RQIA must set out clear improvement measures and use its existing powers where necessary to drive improvement.

DEPARTMENT OF HEALTH

The Department of Health should consider how to support providers to meet the new proposed requirement in the minimum standards for nursing care, residential care homes and domiciliary care. Levelling up from the current average training care workers receive to best practice training would be at an estimated cost of £69.55 per direct care worker working in older people's care, or a total of £2.1m. This total would cover both the cost of the training course (£0.65m) and the cost of staff time (£1.45m). There would be an approximate additional annual cost of £0.34m to train new starters.

CARE PROVIDERS, TRAINING LEADS AND STAFF

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

- Aligned to Tier 2 or Tier 3 as appropriate of the Dementia Learning & Development 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.
- Delivered using 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 Learning and Development Framework, and is at least Tier 2 or Tier 3 (as appropriate) 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 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 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 (DeTDAT tool). The DeTDAT 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 DeTDAT tool provides additional information about best practice related to specific delivery models. We recommended that the DeTDAT tool in full is referred to for evidencing best practice implementation of training by regulators and commissioners. However, the section of the DeDAT tool that refers to the Dementia Training Framework operating in England should be replaced with a mapping exercise in line with the topics covered in the *Dementia Learning and Development Framework for Northern Ireland*.

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 providers might achieve and evidence these standards for commissioners or regulators, such as the RQIA.

STANDARD	DESCRIPTION	RECOMMENDATIONS / RESOURCES / HOW TO EVIDENCE THIS
Design content and materials		
Training maps onto the intended, relevant Dementia Training Standards Framework.	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 Learning and Development Framework* includes a set of learning outcomes associated with each subject area.	Resources include *Dementia Learning and Development Framework*. Mapping tools should be used to evidence how training content relates to the *Dementia Learning and Development 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.	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 Learning and Development 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 equivalent evidence. For example, the *Dementia Learning and Development 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 provide informant 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 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.
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 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 C: FOR COMMISSIONS AND REGULATORS

RESOURCES FOR EVALUATING THE QUALITY OF DEMENTIA TRAINING (ADVICE FOR COMMISSIONERS AND REGULATORS, SUCH AS THE RQIA)

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 Learning and Development Framework*, and is at least Tier 2 or Tier 3 (as appropriate) 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 8-hours dementia specific training in delivery.

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

CHOOSING THE EVIDENCE TO REVIEW

TTraining 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 Framework.	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 Learning and Development 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.	Providers should be able to evidence this standard through the use of Mapping tools to show how training content relates to the *Dementia Learning and Development 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.	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 Learning and Development Framework.*	Providers should provide evidence of the depth of training through 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 peer reviewed or equivalent evidence. For example, the *Dementia Learning and Development 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 informant 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 e-learning careful consideration should be given to how to do this 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 his 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 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 Northern Ireland were based on data provided, 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, in NI the average hourly care worker wage in 2024 was £11.68 and was 3.3% higher than the average hourly wage in England (Alma Economics, 2024). We therefore estimated the hourly wage in Northern Ireland to be 3.3% above the Skills for Care hourly wage estimate for England, giving an hourly wage for Northern Ireland care workers of £12.59.

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

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.

(£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, 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.

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.

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 Northern Ireland, this was the number of people registered with the Northern Ireland Social Care Council as either an adult residential care worker or home care worker available from Northern Ireland Social Care Council (2025).

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.[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 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.

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 Learning and Development 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=19).

TABLE 1

Content and learning outcomes of the Dementia Learning and Development Framework covered by each training package

29 training packages reviewed. Percentage reflects proportion of packages covering each theme. Themes grouped by type.

TOPIC	COUNT OF 29	% COVERAGE
CORE **AWARENESS**		
Dementia awareness	**28**	97%
Communication	**27**	93%
Person-centred care and relationship-centred care	**27**	93%
Promoting physical, psychological and social well-being in dementia care	**24**	83%
Promoting enabling environments	**22**	76%
Working in partnership with families and carers	**17**	59%
SPECIALIST **CORE SKILLS**		
Holistic approach to the management of dementia care	**14**	49%
Equality, cultural diversity and inclusion in dementia care	**16**	55%
Legal and ethical considerations in dementia care	**12**	41%
Palliative care in dementia / end of life dementia care	**12**	41%
Receiving a diagnosis of dementia	**7**	24%
LEADERSHIP **RESEARCH & LEADERSHIP**		
Research and evidence-based practice in dementia care	**9**	31%
Leadership in transforming dementia care	**4**	14%

TABLE 2

Level at which social care staff have received dementia training

n=43 social care staff surveyed. Northern Ireland only. Respondents may report multiple training routes.

TRAINING ROUTE	COUNT OF 43	% OF RESPONDENTS
TOTAL RESPONDENTS	**43**	—
Dementia awareness	35	**90%**
Dementia specific training	17	**44%**
Dementia training as part of induction	14	**36%**
Dementia training as part of formal qualification (NVQ or degree)	10	**26%**
Other	4	**10%**
Care Certificate	1	**3%**

19
Providers surveyed (Northern Ireland) Tables 3 & 4

68%
Top barrier: unable to release staff from duties

63%
Top facilitators: support from management & positive staff engagement

TABLE 3

Barriers to training

% of 19 providers (multi-select). Sorted by frequency.

BARRIER	N	%
Unable to release staff	13	68%
Direct costs of training	7	37%
Training outside paid hours without remuneration	6	32%
High staff turnover	6	32%
Access to digital devices / technology	5	26%
Lack of staff engagement / interest	5	26%
Geography / distance to travel	4	21%
Access to appropriate space for training	2	11%
Staff morale / burnout	2	11%
Access to mentors	2	11%
Language and/or cultural needs of staff	1	5%
Support from management	0	0%
Lack of suitable training	0	0%
Other	0	0%
Have not experienced any barriers	2	1%
Don't know	1	5%

TABLE 4

Facilitators of training

% of 19 providers (multi-select). Sorted by frequency.

FACILITATOR	N	%
Support from management	12	63%
Positive staff engagement	12	63%
Positive cultures of care	9	47%
Skilled and experienced facilitator	7	37%
Group-based learning	5	26%
Access to space for training	5	26%
Renumeration for staff outside paid hours	4	21%
Technology	4	21%
Direct costs for training supported	3	16%
Protected time to reflect	3	16%
Designated training lead / dementia champions	3	16%
Staff incentives	2	11%
Ring-fenced time	1	5%
Adaptability to language or cultural needs of staff	1	5%
Don't know	1	0%
Nothing has helped	0	0%
Other	0	0%


LBU
LEEDS
BECKETT
UNIVERSITY


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


IFF Research