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

Wales Edition

LEEDS BECKETT UNIVERSITY

Alzheimer's Society Cymru

Bydd yn cymryd cymdeithas i guro dementia

It will take a society to beat dementia

IFF Research

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ACKNOWLEDGEMENTS

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
Home Instead
Cardiff University
The University of Kent
IFF Research

FOREWORD

THE LIVED EXPERIENCE INVOLVEMENT GROUP

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

Participating in this research provided an opportunity to explore and understand what was actually happening with dementia training for staff in social care, and why there exists so much variation. We were interested to see what might help with working towards better training, such as in-depth dementia training rather than short dementia awareness sessions. It has been clear to us that dementia care requires understanding that goes beyond basic dementia awareness and the findings of this project underline the scale of the gap and the importance of strengthening dementia training standards. Involvement in this project has given us a better picture of the scale and detail of the training gap in Wales 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

PROFESSOR PAUL WILLIS

PROFESSOR OF ADULT SOCIAL CARE, CARDIFF UNIVERSITY

Supporting the social care workforce to care for people with dementia is one of the key leverages we have for helping the million 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 or supported housing. 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 Wales 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 Good Work: A Dementia Learning and Development Framework for Wales (2016)[1]. 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 delivered in ways that we know to be more effective for promoting learning. This report sets out a strong case for change including an important call for training to extend beyond e-learning and the need to develop the evidence base underpinning good training in dementia-specific care – this is a shared responsibility for researchers, government policy makers, care providers and regulators. Another strength is the focus on best practice case studies in rolling out training that highlight valuable learning from the sector. The cost of delivering good quality training is a critical dimension for providers when assessing how to meet the training needs of their staff – this report highlights this critical issue and sets out the investment required to ensure workers have the right skills and knowledge to deliver good quality care.

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 urge the government to take account of these recommendations and the investment required to enable providers to offer their 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 Northern Ireland are available.

WHO TOOK PART?

Responses were received from 13 social care providers in Wales, reporting on 30 training packages. The survey was completed by 50 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 continue to advance 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 staff currently receive falls short of best practice, which restricts the impact of training and its impact on staff's readiness to deliver high-quality person-centred care.

Specifically, 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 64% 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 (training directed to skilled learners). Compared to the care provider audit, where 87% of training packages offered were described as dementia specific, the staff survey results are much lower showing a contrast between what training is offered by care providers and what training care staff are actually accessing.

A much higher proportion of respondents to the staff survey (88%) reported getting any dementia training, including dementia content within generic training, which may account for 20% of training offered. However, generic training with dementia content is unlikely to meet the threshold for best practice delivery outlined in this report (e.g. effective delivery method, such as sufficient time).

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

This should be given effect by Welsh government through amendments to the relevant statutory guidance for care home and domiciliary support services issued under the Regulation and Inspection of Social Care (Wales) Act 2016, with a requirement for staff to undertake best practice dementia training, namely of at least 8 hours, with content mapped to at least the 'Skilled Worker' level of the Good Work Framework (or an equivalent level of an updated national framework), and with delivery meeting the 5 key components of best practice training (evidence-informed training design; effective delivery method; inclusive digital learning; support and accessibility; and strong leadership to foster long-term impact of training.) The guidance should make clear that this is necessary to comply with Regulation 36 of the guidance (which places a duty on service providers to ensure staff are properly supported, trained, and developed, including ensuring staff receive specialist training as appropriate).

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

KEY DEFINITIONS FOR UNDERSTANDING THIS REPORT

BEST PRACTICE DEMENTIA TRAINING

Best practice training should meet certain minimum requirements on content, delivery and duration. The content of best practice training should be aligned to the Good Work: A Dementia Learning and Development Framework for Wales (2016)[1]. This framework sets out nine learning and development themes, each with associated topics and learning outcomes. The framework describes three levels of learners in the workforce – informed people, skilled people and influencers, and indicates which topics and learning outcomes are relevant to each level of learner. For example, the first theme (dementia awareness and communication) is designed for informed people – all staff in the social care workforce should at least be informed about dementia on this level. Subsequent topics concerning well-being are more involved and targeted to skilled workers with regular contact with people living with dementia, including direct care staff. 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; evidence informed training design, effective delivery method, digital inclusivity, support and accessibility, and strong leadership. It should include interactive in-person delivery, which may be online, provided there is an interactive element with a facilitator (rather than being self-directed e-learning only). Training should be of at least eight hours in total, with individual sessions lasting at least two hours[3].

DEMENTIA AWARENESS TRAINING

Dementia awareness and communication training is an introductory training topic designed to ensure that all staff are at least informed about the needs of people with dementia and the people that support them. It is aimed at the entire health and care workforce, including staff who do not provide direct care. In the Good Work Framework this awareness level training is also described as being aligned to the knowledge and skills included in the Dementia Friends programme (Wales). Training aimed at skilled staff (Skilled People level of the Good Work framework) can include topics of awareness alongside other, more in-depth topics (e.g. well-being theme: meaningful living). 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, etc). Dementia specific training can be delivered at any level of the Good Work Framework[1] , covering any of the topics as standalone topics (including dementia awareness) or multiple topics. Dementia specific training is the recommended approach for the delivery of topics aimed at skilled learners, and it is more likely to align to best practice recommendations in terms of delivery and duration of training.

E-LEARNING

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

WHY IS BEST PRACTICE DEMENTIA TRAINING IMPORTANT IN WALES?

It is estimated that there are around 51,000 people living with dementia in Wales, a figure that is set to rise by 37% to almost 70,000 people by 2040[5]. 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[6], and a high proportion of those receiving home care services have dementia too.

People living with dementia accessing care can experience many unique needs which require support, with wide variation across individuals and the many different conditions within dementia[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 the large numbers of people with dementia accessing social care, with profound levels of need, mandated dementia training for the workforce that fully aligns to published guidance and standards in Wales is absent. The guidance document 'Good Work: A Dementia Learning and Development Framework for Wales (2016)'[1] sets out a rights-based, wellbeing and person-centred approach to dementia care and identifies skills and knowledge for three different groups of people ('Informed', 'Skilled' and 'Influencer'). Social care staff working regularly with people with dementia should have training that covers informed and skilled levels.

Additionally. Social Care Wales produced a toolkit[9] to support organisations to put the Good Work Framework into practice, which includes five building blocks for effective learning and development including values and principles, leadership and governance, structure and planning, delivery of training and development and evaluating impact. Each has a description of what good practice looks like and resources to support achievement of this. Section four of this toolkit also draws on the evidence described in the What Works study [10], and the findings which describe the main features of effective training design and delivery, also set out in this report. The All-Wales Dementia Care Pathway of Standards[11] that applies to all organisations and agencies who support people living with dementia in Wales, includes a standard around all staff being able to participate in person-centred learning and development. The standard supports implementation of the Good Work Framework into practice.

Additionally in Wales, those within the social care workforce are required to be registered with the national regulatory body, Social Care Wales. This can be done through two routes both of which include some dementia specific content: accredited qualification

(City and Guilds level 2 or 3) or employer assessment of competency. It is mandated by Social Care Wales, and part of the Regulation and Inspection of Social Care (Wales) Act (2016)[12], that all social care staff will complete an induction that enables them to undertake their role. If taking the route of employer assessment for registration, staff have up to 6 years to undertake this assessment. As of February 2026, 34% of staff had opted for the employer assessment of competency route, with 4.4% having had their competency confirmed by their employer. Despite registration of social care workers in Wales, there is no current national dataset that captures completion of dementia specific training by this workforce. One of the aims of this report has been to increase our understanding of the extent and quality of dementia training that the workforce in Wales has received.

The 'What Works study' was the most expansive study to date that sought to understand the features of impactful dementia training, informing our understanding of what good quality training looks like. This included a large-scale review of evaluated education and training programmes[10], a national audit of dementia education and training in England[13] and in-depth case studies within social care provider organisations[14]. 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 in England. As yet, we do not have the equivalent evidence or understanding for the workforce in Wales, which is why we have explored this in the current report.

A range of evidence[15,16] has also consistently reported that a well-trained workforce provides better quality care. This evidence has been bought together and presented in the 2024 report from Alzheimer's Society 'Because We're Human Too: Why dementia training for care workers matters, and how to deliver it'[b].

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 (p25).

This new report uses these five key components to define best practice dementia training and uses the key components to assess training currently being provided to care staff across the social care sector in Wales. There is no current evidence as to the extent of dementia specific training received by social care staff in Wales. Equivalent data in England from the Skills for Care Audit[17], provided information about specified types of training (indicating that 38% of staff had undertaken dementia specific training), but did not collect information about all types of dementia training staff may have undertaken from the provider perspective. Whilst the What Works study did provide information from the provider perspective, this was not targeted to the social care sector and requires updating.

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b https://www.socialcaredata.wales/WorkforceSummary

Our new evidence and data responds to the gaps in knowledge set out here, 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 in Wales, 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 Wales.

RESEARCH METHODOLOGY

The information underpinning this report was collected by

METHOD 01

Online Audit

13 PROVIDERS
30 PACKAGES

- 13 Care home and home care providers reporting about 30 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 Good Work Framework and assessed against the five key components of impactful dementia training
- Audit available in Welsh and English

METHOD 02

Online Survey

50 CARE STAFF

- Completed by 50 social care staff
- Included questions about training they have completed, knowledge and understanding of dementia
- Survey available in English and Welsh Language

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 WALES

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

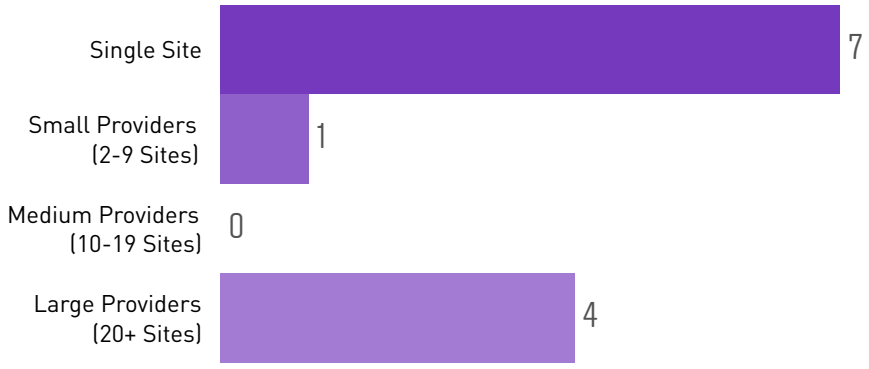
The quality of dementia training was assessed using an audit that was shared with providers with the aim of understanding the training delivered in the social care sector. A wide range of providers responded representing **45-52 care homes sites and sites with home care services**[c].

Thirteen care providers responded to the audit including 9 care home providers, 5 home care services, and one local authority.

Of the 13 respondents, 7 of the providers represented single sites or regions (home care), one represented small providers (2-9 sites), and four large providers (20+ sites)[d]. The other respondent was the local authority.

FIGURE 1

Overview of the size of providers



c This is broken down as 27 care home sites, 11 home care sites and 5 providers who provide both. Data presented as a range due to response parameters in the audit.

d Some of the large providers were cross nation providers – so data on the number of sites represented included the Wales sites only

The respondents were largely representative of the sector in terms of the size of the providers who responded. In Wales small to medium providers make up a significant proportion of the sector, with many of providers just having one or a few care homes, and just a handful of large-scale providers.

Of the 13 respondents six (46%) had 1-49 staff, three (23%) with 50-99 staff, three (23%) had 500+ staff, with the larger providers the multination providers. One provider (8%) did not know.

The providers who responded gave information in the audit about the number of training packages they offer to staff. Five providers (42%) reported one package, with the rest reporting on multiple training packages: three providers (25%) reported three packages, two providers (17%) reported four packages and one provider (8%) reported on five packages, and one provider (8%) offering more than five packages.

Of the 30 packages, 26 (87%) were dementia specific training and four (13%) 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). Sixteen (53%) were part of a formal induction programme, and 14 (47%) were not. Frequency of delivery was explored, but for 30% of the packages this was not known, while 13% of the training packages had been delivered less than 10 times in the last 5 years, and 20% between 10-49 times, and 10% 50-99 times, with 27% being delivered on over 100 occasions.

For the 30 packages, 43% were bought in as outsourced training, 10% involved staff attending training off site with an external provider, and 37% were developed in house.

Respondents to the audit estimated the reach of the 30 training packages for direct care staff without professional registration. The majority of providers (71%) reported their training was reaching at least 76% of their workforce.

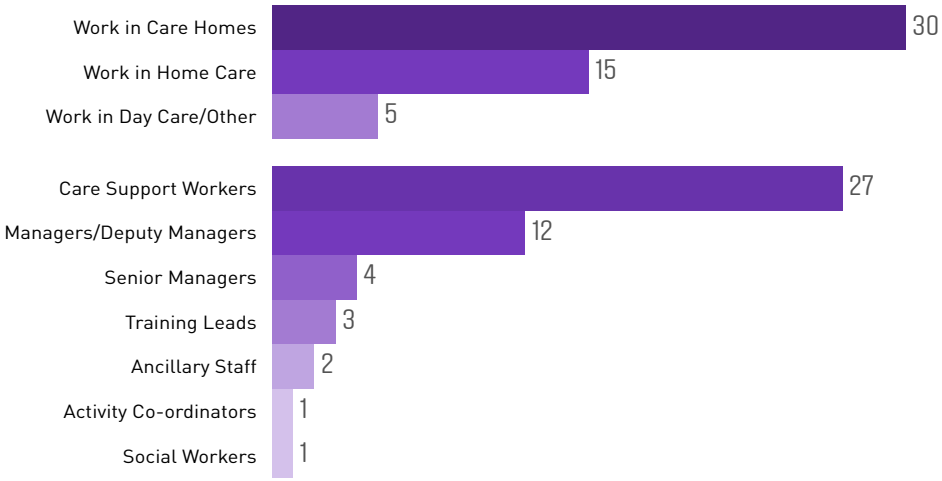
WHAT DEMENTIA TRAINING ARE THE SOCIAL CARE WORKFORCE RECEIVING IN WALES

The staff survey targeted social care staff in Wales and asked about the dementia training they had received. A total of 50 responses were received. This included 27 care support workers or senior support workers, 22 managers, service managers or deputy managers, four senior management, three training leads, two ancillary staff, and one activity co-ordinator. Of the 50 respondents, 30 worked in the care homes and 15 in home care (five described as other).

FIGURE 2

Distribution of staff survey respondents by job role and service setting

(n= 50)



In total 56% of these staff had more than five years' experience, this was comparable with the (Skills for Care) data in England about the sector, the only data we have which is comparable for the workforce, in which 57% care home staff had more than five years' experience. The majority identified as female (88%) and white British (72%).

Just over half (64%) of respondents had completed dementia specific training, and up to 88% had completed any dementia training, with only 12% stating they had 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 Wales, the *Good Work: A Dementia Learning and Development Framework for Wales (2016)*[1] 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 Good Work Framework[1] describes nine themes that should be covered, with topic and learning outcomes aligned to each theme. The first theme relates to dementia awareness and communication (corresponding directly to the topics covered by dementia friends training), with the others covering well-being. The learning outcomes for each theme are aligned to three training levels based on a staff member's intended level of expertise:

Level 1: Informed People – This level of learning includes only one theme – dementia awareness and communication. It is aligned to the knowledge and skills associated with the Dementia Friends training programme in Wales, and essential communication skills. is It is aimed at the entire health and care workforce, including staff who do not provide direct care.

Level 2: Skilled People - Skilled people are informed but will also develop more detailed and comprehensive knowledge and skills across a range of key learning and development topics. They will have spent time providing care and support for people with dementia.

Level 3: Influencers - Influencers are people who are Informed, possibly Skilled and who also have a management, leadership and/or strategic role. In our audit we did not ask for details of training for influencers as in the framework these are presented as impact statements rather than learning outcomes, so cannot be captured in the same way.

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 against the Good Work: A Dementia Learning and Development Framework for Wales (2016)[1]. Similarly, in the staff survey we explored the type and level of training care staff report they have completed.

KEY FINDINGS

1 **TRAINING LEVEL**

70% OF TRAINING OFFERED IS TARGETED TO SKILLED WORKERS
Of the 30 packages audited, 70% were described as Level 2 aimed at skilled workers offering more than dementia awareness.

2 **STAFF PERCEPTION**

86% OF STAFF REPORTED RECEIVING DEMENTIA AWARENESS TRAINING
Despite providers offering skilled-level training, the majority of staff reported receiving only dementia awareness training.

3 **FALLS SHORT OF REQUIREMENT**

TRAINING AT DEMENTIA AWARENESS LEVEL 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. Direct care staff need Level 2 knowledge and skills to provide the right standard of care.

4 **INDUCTION GAP**

OVER A THIRD OF NEW CARE WORKERS MAY HAVE NO DEMENTIA TRAINING AT ALL
Only 64% of staff said dementia training was included in their induction, meaning a third of staff may be starting work having not received any dementia training at all.

It is recommended that direct care staff access training across relevant topics at Level 2 – skilled people. The training aimed at informed people (aligned to dementia friends 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 Good Work: Dementia learning and development framework for Wales and were asked to map the level and topics covered in the training against it.

FIGURE 3

Overview of Tiers covered by training packages

LEVEL 1 · **INFORMED PEOPLE**

77%

Dementia awareness and communication. Aimed at all staff including non-direct care.

LEVEL 2 · **SKILLED PEOPLE**

70%

Detailed knowledge across key topics. For those providing direct care and support.

LEVEL 3 · **INFLUENCERS**

47%

Management, leadership and strategic roles. Not assessed by learning outcomes in this audit.

SOURCE: audit of 30 reported training packages · Good Work: A Learning and Development Framework

In addition to the level of training, respondents were also asked to state which of the training topics were covered in their reported packages (see appendix F, table 1 for overview). Of the 30 packages, 10 (33%) included the topic of dementia awareness and communication training (being a dementia friend). This is fewer than the 77% of packages that were described at Level 1 suggesting that the *Good Work: A Learning and Development Framework* is misunderstood, and in fact the topics being covered are more aligned to the learning outcomes at Level 2 (skilled people).

83% of packages included the topics (under well-being), of physical and mental health, and meaningful living. Whilst 87% covered the physical environment. All eight of the Level 2 (skilled people) topics were covered by more than 67% of the packages. All these topics are critical to the delivery of social care support and play a significant role in the delivery of person-centred care and the audit results suggests that in Wales, training covering the appropriate topics at the appropriate level in the majority of training packages.

WHAT TRAINING ARE SOCIAL CARE STAFF GETTING?

The findings from the audit (what providers say they are delivering) were compared to the perspectives of front-line social care workers who completed the staff workforce survey. In the staff survey respondents described the majority of training that they had received as dementia awareness training. This appears to contrast the audit findings in which 70% of training is at a higher level than dementia awareness and aimed at skilled workers. Only 64% of staff in the survey said they had accessed dementia specific training (explored later in the section on training delivery). 32% said they had completed a care certificate[e] which included dementia content and 64% of staff survey respondents said they had received dementia training as part of their induction, which means over a third (36%) 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 40% had completed a formal qualification[f], which included dementia content.

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

64%
Received training as part of induction

36%
No training at induction

64%
Accessed dementia specific training

40%
Completed formal qualification which included dementia content

Audit findings suggest most training is at a skilled worker level, yet staff themselves describe mostly receiving basic dementia awareness training suggesting a possible gap between what providers report delivering and what staff experience receiving

e The Care Certificate is recognised as an indicator of competence in England

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

40% OF TRAINING PACKAGES WERE EVIDENCE-BASED

Less than half of training was evidence based, with only 6% citing the use of national guidance. Most training includes views and experiences of people with dementia, though only 30% involved people with dementia in its development.

02 — DELIVERY

OVER HALF OF TRAINING DELIVERED BY E-LEARNING

With 30% using this as the only method of delivery. 70% of the training was 4 hours or less in duration, with half of training packagers offering only 1–2 hours of dementia-specific training content.

03 — INCLUSIVE DIGITAL APPROACH

E-LEARNING IS THE DOMINANT APPROACH TO DELIVERY

Despite e-learning being the dominant delivery method, only one provider perceived digital access as a potential barrier to training.

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 also not offering support to access training such as translation.

05 — STRONG LEADERSHIP

MOST TRAINING PACKAGES DO NOT DEVELOP THE NEXT GENERATION OF LEADERS

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

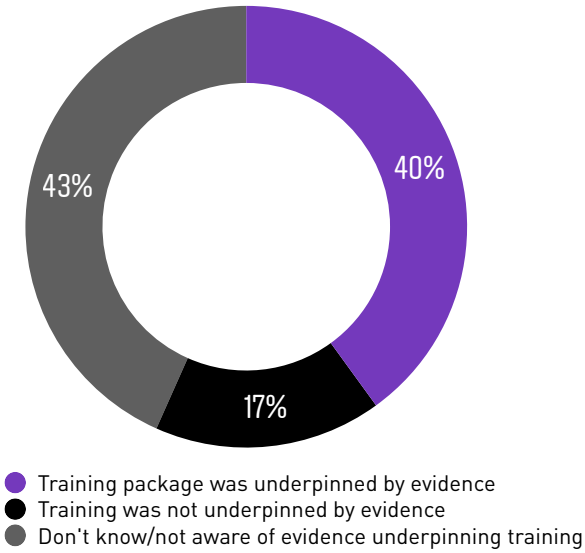
1. EVIDENCE INFORMED TRAINING DESIGN

Training design should be based on the best available scientific research, data and facts. Whilst in development, the most recent Dementia Strategy for Wales 2026-2036 explicitly cites the importance of evidence based training[g]. Training should also integrate expert knowledge such as professional expertise and lived experience. In Wales, the Good Work: A Dementia Learning and Development Framework for Wales (2016)[1], which is underpinned by evidence, provides a benchmarked standard against which evidence-based training can be developed in terms of determining priorities or measured in the recommended outcomes focused approach.

Of the 30 training packages reported in our audit, 12 (40%) said the training package was underpinned by evidence, 13 (43%) said they did not know or were not aware of the evidence that underpinned their training, and 5 (17%) said their training was not underpinned by evidence. These findings suggest that more than a third of training packages are not informed by evidence, creating a risk that these training packages do not meet best practice standards.

FIGURE 4

How many packages are evidence based



For the packages that were reported as being underpinned by evidence, a range of evidence sources were cited –most commonly 4 (13%) research, 2 (7%) e-learning for Health (e-LFH) and 1 (3%) said Alzheimer Society. 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 Good Work: A Dementia learning and development Framework, and of those that are, many of them are unable to expand on the evidence behind their training.

g https://www.gov.wales/draft-dementia-strategy-wales-2026-2036

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 (87%) included examples of lived experience in the materials and 9 (30%) of packages had involved people with lived experience in their development. While it was good to see four (13%) 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 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 30 training packages, 18 (60%) said they included an assessed component, whilst 10 (33%) said they did not. Out of the 65 that included an assessed component, 17 (94%) were assessed by questions to check understanding (e.g. a quiz), four (22%) observations of practice, four (22%) 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. Having an outcomes focused approach to measuring the impact of training is a key feature of good practice cited in Welsh social policy and the Good Work framework.

The impact of training on staff had been evaluated for 14 (47%) of training package and had not been evaluated for 10 (33%) of training packages. Of the 14 (47%) of training packages that had been evaluated, this most commonly took the form of informal feedback from staff, which was reported for nine of the packages (64%).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, as opposed to generic training that includes dementia content, is a recommended approach for the delivery of topics designed for the skilled learner level of the Good Work Framework[1]. 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 members role, and is at least eight hours duration[13].

DELIVERY OF DEMENTIA SPECIFIC TRAINING

Of the 30 training packages reported in our audit, 26 (87%) were dementia specific training and four (13%) were more general training with a dementia component. This was assessed further according to the topics covered in the Good Work Framework (Appendix F, table 1). Of the 10 (33%) packages covering the topic of dementia awareness and communication (being a dementia friend), all were delivered as dementia specific training. For the remaining topics aimed at skilled learner level (Level 2) there were fairly consistent patterns as to whether the topics were being covered by specific or generic training – between 65% and 85% of packages covered each topic area regardless of whether they were delivered as specific or generic training. The exception to this was the physical and mental health topic and the physical environment topic, which were covered in 100% (all four) of the generic training packages reported.

Although the audit of providers showed a high proportion of dementia specific training packages (87%), 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 staff survey, we found that only 64% of staff were receiving dementia specific training, highlighting a contrast between what training is available from care providers (87% dementia specific training) and what training is being accessed by care staff. In the survey 88% reported getting any dementia training, including dementia content within generic training. Examples of non-dementia specific training included induction and the care certificate. These findings are important as they suggest that 25% of staff are getting dementia training that is generic or non-specific dementia training. This approach to training is unlikely to be sufficient to equip staff to deliver high-quality person-centred care, as generic training with dementia content is unlikely to meet the threshold for best practice delivery outlined in this report.

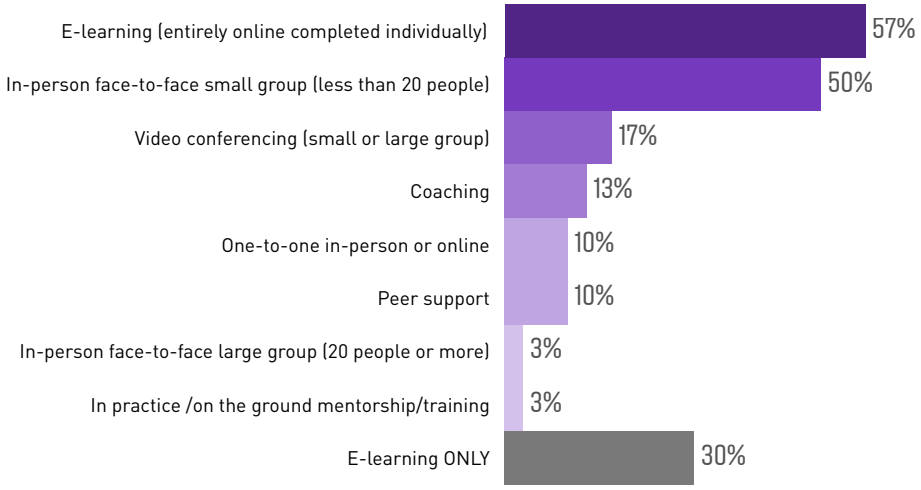
METHOD OF TRAINING DELIVERY

In our audit, over half, 17 (57%) of the 30 packages, were completed using e-learning - delivery that is computer-based without the input of "live" interaction with facilitators or other learners. Of the 17 packages reported, 9 (30% of the overall packages) used e-learning as the only method of delivery. Research has shown that e-learning delivered in this way is less likely to be positively received by staff and is less likely to provide them with the right knowledge and skills to be able to deliver good dementia care.

In terms of the other delivery methods used – 15 (50%) of packages were in-person, face-to-face, small group training[h] – aligning with a recommended delivery approach. Providers reported one (3%) package used in person face-to-face in large groups, two (7%) used video conferencing, three (10%) used one-to-one in-person or online, four (16%)used mentoring or coaching and seven (6%) used peer support.

FIGURE 5

Method of training delivery



LENGTH OF TRAINING

In addition to how training is delivered, duration of training is also important. For dementia training, the evidence-base indicates an overall training duration of at least 8 hours (over one or more sessions) is more likely to have a meaningful impact on learning[18]. 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 30 training packages, 20 (67%) were standalone sessions, and 10 (33%) 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. In the audit 15 (50%) packages offered 1-2 hours of dementia specific training content, six (20%) offered 3-4 hours dementia specific content, one (3%) offered 5-7 hours, four packages (13 %) offered 8-19 hours and two packages (7%) offered more than 20 hours training. Data wasn't provided for two packages.

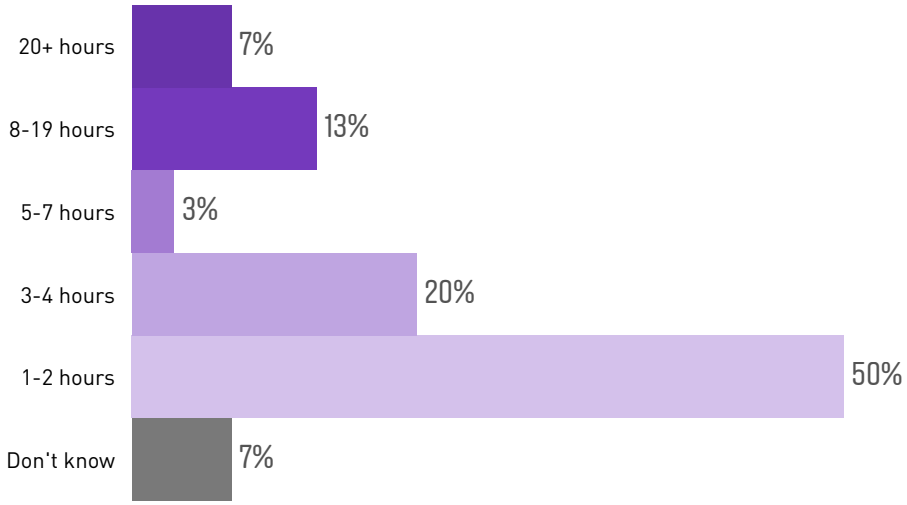
These findings suggest that only 20% of training currently being offered met the best practice threshold of more than eight hours. Furthermore, a larger proportion of the e-learning only training was of shorter length, with 67% of training delivered by e-learning lasting only 1-2 hours. If these packages are the only dementia training being provided to social care staff, the training provided is not sufficient to be having a

h Small groups fewer than 20 people, large groups 20 people or more

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[19]. 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 11 (37%) of the packages were delivered in-house by external trainers, 13 (43%) were delivered by in-house specialist trainers, three (10%) by in-house clinical/other staff, and five (17%) by in-house dementia champions. Overall, 19 (63%) packages were delivered by in-house staff.

While over half (63%) 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 (37%) 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 the most often used method of training delivery (57%), the audit indicated access and support for technology-based learning is not being widely considered in the sector. Only one provider identified 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[i]. No respondents to this question said they provided devices to staff, three said they covered costs (e.g. wifi, purchase of equipment), and one 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 Wales are being offered to staff at the skilled learner level,. However, this still means that 30% are not being targeted to the required skilled learner level, and may be at the informed learner (dementia friends) level only.

The audit asked which staff groups each of the training packages were intended for. Of the 30 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, and four (13%) to staff with professional qualifications (e.g. nurses). In terms of accessibility, we would expect training to be targeted to the learner's role and their staff group.

In addition to its level, the accessibility of the training is an important feature of best practice. Providers gave information on accessibility for 13 training packages. Translated materials or services were provided in only three (23%) of the reported packages. In addition to accessibility, 23% of providers said they do not offer support to access or understand training, and 46% 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 (77%) did not include opportunities for the development of staff who could support and lead implementation of good dementia care, such as dementia champions. Four (13%) of the 30 training packages included the opportunity to train staff to be dementia champions. Of these two said all staff were eligible to be trained as dementia champions, one said this was managers only, while two specified direct care staff only were eligible.

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i Four providers responded to this question

WORKFORCE KNOWLEDGE AND ATTITUDES

The social care workforce requires best practice dementia training to ensure sufficient knowledge and understanding about dementia. It is also vital to recognise just how important attitudes towards dementia are– individual attitudes and beliefs (such as holding stigmatising views about dementia), can act as a barrier to learning and motivation to improve practice[20]. 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[21]. Good quality dementia training can increase staff competency and attitudes towards dementia[22]. 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[19].

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 [23-26]. In this report we explored staff knowledge and attitudes using both standardised measures of knowledge and confidence and creative approaches.

KEY FINDINGS

KNOWLEDGE

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

ATTITUDES TO DEMENTIA

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

CONFIDENCE

Only 58% 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 88% of staff accessing any dementia training, the standardised test of knowledge that we delivered in the survey indicated that up to a third (34%) 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)[27] below.

Our survey of the social care workforce asked participants (n=50) to complete the DKAS 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.

Many of the respondents (72%) answered the questions around communication and behaviour all or majority correctly (10-12 points out of a maximum 12). Similarly 60% scored 10-12 out of 12 for the care considerations component. However, on the communication and behaviour scale and care considerations scale respondents only answered 16% and 28% (respectively) as mostly correct (7 to 9 points). On both scales 6% answered less than half correctly. This indicates that although many of the survey respondents had completed some kind of dementia training, levels of basic dementia knowledge are still moderate (16%-28%) to low (6%) for up to 34% of social care staff (those scoring 9 or less on at least one component of the scale).

This corresponds to previous research findings[19] 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 being an informed learner), 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 (as a skilled learner).

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

Most (90%) staff agreed or strongly agreed that they had received sufficient dementia training to enable them to care for people with dementia. Further, 90% strongly agreed or agreed that the training they had completed had equipped them to better care for people with dementia. However, the wider findings of this report suggest that staff are not in fact being given training that is delivered appropriately to equip them to offer 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 (SCIDS 28), only 58% 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 (skilled learners), 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 home care 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 (E&F) identified that the care Arthur received fell below the standard they would expect in their own practice.

> *So, you know, the... It's their home, it's their life. You're coming in, you're disturbing it. It's not what they want. You know, you're putting clothes on him that he doesn't want to wear, you know... Somebody doesn't want to wear a skirt, don't put a skirt on them. Do you know what I mean?... Like, how would you feel if you were in that position? Because I wouldn't like it. Yeah. And nobody's talking to them. I don't think Leanne can speak up either. Like you said, this isn't what he wants"*
>
> (STAFF PROVIDER F HOME CARE)

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

> *And he likes to watch birds so we can put some stickers uh on his window so it will feels like you know maybe he feels like birds are there ... I will leave the resident like what time they likes to wake up so I will ask them like I'll show in two hands like some sometimes they can't uh take decisions so if we are showing them for example like food or dress so they can do gestures so we may understand they like this clothes or that clothes yeah so we help them according to that yeah and so I'll take him to garden and shows like you know the birds fences whatever he likes*
>
> (STAFF E CARE HOME)

And some clearly identified the importance of and missed opportunities for involving the family. The LEIG did identify that not all staff were able to pick up on how to involve family, so it was notable when they did.

> *You need to speak to the family soon after admission that day may not be quite good you just you know have to let it go and just introduce yourself introduce the whole home and the team because they might be stressed the move is always hard hardest part I think the day one will be quite stressful for the family as well so what we do is we'll do a review in seven day's time where we actually show*

> *the whole care plan…. So they [family] should have given her an opportunity to go through the care plan, making sure like, you know, we have written everything correctly for the team so that the team could follow the right thing.*
> (CARE HOME E)

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:

> *They just followed the care plan. They didn't ask the person what their choices are. They didn't have proper communication or They didn't even have a good chat with him. So that's the thing which made him and his family upset. What would you do differently? Like I said in my previous chat, I will definitely ask him what his choices are*
> (STAFF CARE HOME E)

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 WALES?

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 E CARE HOMES

CARE HOME GROUP · 7 SITES

PROVIDER TYPE
Residential / Nursing

TRAINING MODEL
In-house, delivered entirely in person by a dedicated regional dementia practitioner

IN BRIEF
Dedicated regional dementia practitioner across eight care homes. Evidence-based modules grounded in enriched model and six senses framework. Practice development toolkit supplements mandatory induction. Induction includes a dementia component

In-person delivery througout

Ensures consistency, quality control, and direct translation of learning into practice through an ongoing mentoring and trouble-shooting model

COMPONENTS MET

- Evidence informed training design
- Effective delivery method
- Strong leadership

SUMMARY

This case study demonstrates a strong example of an evidence-based approach to the development of a suite of training materials that are used across an organisation. Dedicated training leads create a network of mentoring for staff, and opportunities to build knowledge through informal learning.

BACKGROUND

This large care home provider has homes in England and seven care homes in Wales who provide specialist dementia care. The core dementia specific offer is two mandatory dementia training modules delivered in-person (one for all staff and the latter for direct care staff):

> *Essentially you've got modules on essential parts of dementia training. So the first one for us is relationship centred care because that's the model that [provider] uses, but there's a lot of overlap with person-centred care there, so relationship centred care and then we have a module that is on what we call [redacted], which is essentially (about) ... responding to behaviour in dementia*
> (SENIOR DEMENTIA SPECIALIST)

The provider also offers a range of non-mandatory training that is described as being part of the "practice development toolkit." One staff member provides all of the in person training and ensures staff have access to the dementia training they need – meeting the criteria of an in-house training specialist described as good practice in this report.

EVIDENCE INFORMED TRAINING DESIGN AND CONTENT

The training modules, both mandatory and non-mandatory, are evidence based, and have been recently updated. The staff that we spoke to had a good understanding of the content of the training, and the senior dementia specialist and training leads were able to cite the underpinning evidence that informed the training

For example, for the practice development toolkit, staff spoke to the model that underpinned the components of the training:

> *And these are all three hour modules: a module on communication, a module on life history, a module on environment, a module on meaningful occupation, and a module on brain basics. So it's essentially the components of the enriched model of dementia care with the exception of health. So health is sort of combined through the other ones.*
> (SENIOR DEMENTIA SPECIALIST)

EFFECTIVE AND INCLUSIVE DELIVERY METHOD

All of the training in Wales is delivered in-person by the regional dementia support. After the induction, which includes a dementia component, the practitioner meets with staff regularly to deliver toolkit sessions. These are the dementia specific sessions for direct care staff, which are delivered in-person – aligning with the best practice approach described in this report.

> *So aside from the induction, we do what we call dementia practice development sessions. So one of the sessions is around communication, how you might approach somebody that's living with dementia, how you might change your own communication style or give them more time to process information. And within that session, I also use the visual simulation glasses that give you those ten different visual impairments so that the team can experience what it could be like if you were in a room and a care team member maybe knocked at the door and they were living with cataracts, so how they might need to use a different approach in letting somebody know that they're there and we do sessions with a communication session I do like to.*

> *The troubleshooting role that the training lead provides also provides additional opportunities to translate learning into practice – in a less formalised way.*

> *So it could be that we're thinking about an increase in behaviour reports, which would be our behaviour charts and that we have identified maybe that the team either need a refresher on behaviour based training or on reporting and recording. So then I might come into the home and meet with those team members and deliver a session around that. Or it could be that we're working with a team on how they communicate with the person following some of those behaviour charts.*

This was echoed in the staff interviews we undertook, in which staff cited examples of where they were able to put into practice how the training helped interpretation of residents behaviour

> *Yeah, in-house trainers. And we covered, again, things like residents were restless, residents were constantly walking around, explaining what the situation was and why. Little silly things as well, but things that I found really interesting, like people with Parkinson's and things. You get to an area, say the floor, the area, because I found this really interesting. If it's this floor and then it's carpet and there's a divider, they tend to step over. And I used to think, why? But it's because it's a different, you know, their view is different.*

CASE OVERVIEW

PROVIDER F HOME CARE GROUP

NATIONAL · FRANCHISE MODEL

PROVIDER TYPE
Domiciliary / Home Care

TRAINING MODEL
Blended – combination of e-learning and in-person/virtual delivery

IN BRIEF
External expertise embedded into centralised in-house content. Blended model with mandatory face-to-face final module. Dementia champions course (16 hrs) builds org-wide capacity. Dedicated Wales training lead supports local delivery.

10.5 hrs
length of training exceeds 8 hours best practice standard

COMPONENTS MET

- Evidence informed design
- Effective delivery method
- Strong leadership

SUMMARY

The training offered by this home care provider demonstrates a suite of training that has been developed in house alongside external input and expertise bought where required. This was especially true in the initial phases of the training development to ensure that the training is contemporary and evidence based. The current suite of training offers a multilayered approach, from induction to dementia champions, demonstrating an organisational commitment to a whole systems approach and commitment to learning which is echoed in the feedback of staff. The local provider is a franchisee, with the training drawn from the central organisation. The local training lead felt that the suite of training offered was really accessible, enabling them to support staff from induction and continue their development. However, some staff articulated a clear preference for an in-person approach, expressing a need for this and the opportunity to discuss tricky care scenarios with their peers, with the e-learning supplementing knowledge.

BACKGROUND

This large national domiciliary care provider operates on a franchise model with a centralised training offer. The dementia specific training programme was developed in collaboration with a dementia specialist with expertise in person-centred dementia care practice, and has been reviewed and revised over several years, bringing in other providers and partnerships for expertise on specific topic areas (e.g. end of life care).

Dementia training also features as part of the mandatory induction for all staff (in person and online), and a dementia champions course available to staff, including care professionals, field care supervisors, care managers, schedulers and other members of the office team. The dementia care champions training is a blend of virtually delivered sessions and e-learning modules.

In Wales, to support the delivery of training the provider has a dedicated training lead. The training lead described the franchise as closely adhering to the delivery of training provided by central office. However, additionally they describe providing training to meet the needs of clients if it comes up on an ad hoc basis rather than according to a prescribed schedule.

> *If we have a client with a specific need, like [training lead] mentioned, trans-dermal patch training or mental health, alcohol abuse and things like that, then [training lead] will allocate [additional training].*
> (LOCAL MANAGEMENT)

EVIDENCE INFORMED TRAINING DESIGN AND CONTENT

This provider described the development of the dementia training programme having in-volved engaging with a range of subject experts to ensure that it is evidence based

> *We always like to engage in subject matter experts, so we have a really good relationship with it's called the [x] partnership, strangely enough, which is a charity based in the Northwest. And they also have a specialist dementia team as well. So we really collaborated with them for their sort of knowledge because we wanted to make sure ... whatever is in the training you know is current best practice. You know there's nothing in there that you know is old hat or isn't, you know, really up to date etcetera.*
> (CENTRAL TRAINING LEAD)

EFFECTIVE AND INCLUSIVE DELIVERY METHOD

The dementia programme is delivered by blended learning, with the initial dementia awareness module purely e-learning and modules two to four that can be delivered online or in-person, and the last module requiring face to face delivery. In its entirety the dementia programme is 10 and a half hours long.

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

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

The franchisee in Wales has chosen to deliver the initial induction using a blended approach too, to ensure that all staff have had a sound introduction to dementia before seeing clients:

> *So the dementia training that we do during induction, we do a lot of sort of face to face scenario based sort of dementia training in which talks about how you would approach people with dementia. and how different approaches can work. And then they also have dementia awareness e-learning, which they do, which goes through the different types of dementia and the symptoms of dementia and how you can then support somebody with a dementia diagnosis. So usually, it works that in the morning it's face to face training with myself and then in the afternoons they're doing that e-learning.*

> *So that covers everything that they need to know basically. So personal care, medication administration, food hygiene, infection control, everything that they need to to do their role basically and then within that.*
> (LOCAL TRAINING LEAD)

In general, staff value the flexibility and ongoing nature of the training offer. However, some staff felt it didn't support their needs as much:

> *Perhaps maybe role play where your trainer would, because you know I've had some difficult clients with Alzheimer's ... yeah doing that instead of reading because ... I'm not a person who reads to learn I need to speak and visually see you yeah I don't know maybe that would be helpful like just someone role play yeah role player yeah*
> [CARE STAFF SITE F1]

> *no I agree role playing would be good because as much as the training is good and the way it's delivered is really good because we can't use clients names sometimes it's difficult to actually i suppose visualize how somebody's going to be... It's very generic on e-learning. It's read this, this is what's happened, and you click, and it gives you several answers. And you best guess.*
> [CARE STAFF SITE F2]

Some staff felt that the e-learning had a tendency to be too superficial and tick box, and ideally they would like to know more, specifically, around the individual.

> *That would help me with my job? Yeah. I think dementia, Alzheimer's is so complicated. I don't really think talking about complexities of the brain and everything, I don't think it would help us in our jobs. I don't think we, I think it could all be too scientific, too much...I think if when you've got a new client, you knew a bit more, it's all very well saying, I've got memory problems, I'm going to a memory clinic, but I think it would be handy to know So if it's all confidential, it'd be handy to know more about that person.*
> (CARE STAFF SITE F)

STRONG LEADERSHIP

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

> *For our key players, so you know the people in the offices that the care managers, that the schedulers, the field care supervised, etcetera, we didn't have anything in place for them. So the. Champions in dementia care course. It's 16 hours studying in total, so there's two full virtual days separated by a week. And then there's another four Learning e-learning modules for them to complete, And the feedback we get from it because it's sort of part of the impact of it is that it makes or it helps those people who are working in the office, for example, to understand the impact some of their decisions.*
> (CENTRAL TRAINING LEAD)

WHAT DOES BEST PRACTICE DEMENTIA TRAINING COST IN WALES?

So far, this report has highlighted our assessment of the quality and reach of current dementia training for the social care workforce in Wales. We've also outlined, using previous research, the key components of best practice dementia training. Our findings suggest that dementia training is being provided, and whilst often at the right level for skilled staff, this is not consistent. More so, 57% of current training is e-learning, and 80% of training is too short in duration to maximise benefits for learners. To better equip the current and future social care workforce, we need to progress to training delivered in the right way to provide 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 Wales using data provided from our dementia training audit across all three nations (England, Wales and Northern Ireland). An explanation of what is included in these costs, and how our audit data was used to calculate them, is outlined in Appendix E. 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.

The table below provides the estimated average total cost of for what training is currently being delivered in Wales 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 Wales, by training course type

NOTES

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

TRAINING COURSE TYPE	AVERAGE TOTAL COST
e-learning	£67.11
in-person (weighted average)	£143.05
external	£224.12
internal	£79.90
OVERALL	£133.13

Average staff cost for attending training is **£66.77** in all estimates.

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

Applying this duration of training (1-2 hours) shows a lower cost. The table below also suggests that providers in our audit, who are most commonly only providing 1-2 hours of e-learning, are spending as little as £19.89 per staff member on dementia training:

TABLE 2

Estimated average cost of dementia training for 1-2hrs for a care worker in Wales, 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	£19.89
in-person (weighted average)	£91.52
external	£176.91
internal	£25.00
OVERALL	£82.16

Average staff cost for attending training is **£19.56** 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 eight 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 Wales

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)	£185.04
external	£264.95
internal	£122.79

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

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

THE COST GAP

To estimate current costs of dementia training to the sector at a national level, estimates were required on the number of staff trained. Data from the audit suggested that the average training course in the sample had been completed by 76% 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 Wales, this was all care workers and senior care workers employed in residential care and home care, which is 42,082, as indicated by Social Care Wales (2024).

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[j]. 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.[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 **£2.2m** (£1.6m–£2.8m)	CURRENT TRAINING **£2.2m**	CURRENT TRAINING **£4.4m**
BEST PRACTICE **£4.2m**	BEST PRACTICE **£3.0m**	BEST PRACTICE **£7.2m**

NOTES

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

j 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.

k This assumes that staff to resident ratios are consistent across younger and older adult homes. We used the estimate from England as the best estimate of this proportion available. Equivalent data in Wales does not exist.

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 difference between the national cost estimate for training currently delivered to the social care workforce and the best practice cost estimate for each country is the static estimate of how much extra it would cost to ensure all current direct care staff are dementia trained according to best practice (i.e. 8hrs and in-person).

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 (Skills for Care, 2025). As an indication of this dynamic cost, we estimate the one-year cost gap for training all new staff from outside adult social care (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 (Skills for Care, 2025)[m]. Using these figures, alongside the estimate of FTE staff working with older adults in Wales, this suggests that there were 6,251 new starters from outside adult social care in 2025. Taking this figure together with the cost per FTE staff member working with older adults of adapting to best practice training (£72.32), this would give a one-year total cost gap to train new starters using best practice on top of current training of £0.45m.

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 £2.8m (£2m total staff cost and £0.8m total training delivery cost) for Wales. **Adopting best practice training for the older adult care workforce would be at an estimated cost of £2.8m, or £72.32 per FTE staff member working with older adults. If the cost to train new starters is also included (£0.45m) this is a total of £3.25m.** Given that in our audit, nearly 40% were developing training in house and meeting the associated costs, and of the providers paying for external training 66% were meeting the costs, it will likely be challenging for providers alone to fund this shortfall.

m Since Wales specific data regarding new starters is unavailable England % estimates have been used

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

The case for change in the way that training is developed and delivered to the workforce is clear- 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. This 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:

- Despite 70% of training offered by providers being targeted at the skilled level, care staff most often report undertaking training at a level of dementia awareness, which is insufficient to support the delivery of high quality person centred care
- There is limited coaching, mentoring or supervision, only about 20% includes peer support, mentoring or reflective learning, which are core elements of good practice
- Training is heavily reliant on e-learning (around half of all training is delivered in this way), with 30% of training using e-learning as the only method
- Training is too short to have sufficient impact for learning, 70% of training was four hours or less, most often 1-2 hours, falling significantly below the recommended 8-hour threshold
- Only 40% of the training reported was evidence based, with providers struggling to cite the evidence underpinning training
- Few providers use the recognised national framework, the Good Work: A Dementia Learning and Development Framework for Wales (2016)[1]
- 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. Providers rarely supply devices, cover costs, or provide digital support

Despite these issues, our findings describe a workforce that is positive and willing, with 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 homecare and care home staff.

This should be given effect by Welsh government through amendments to the relevant statutory guidance for care home and domiciliary support services issued under the Regulation and Inspection of Social Care (Wales) Act 2016, with a requirement for staff to undertake best practice dementia training, namely of at least eight hours, with content mapped to at least the 'Skilled Worker' level of the Good Work Framework (or an equivalent level of an updated national framework), and with delivery meeting the five key components of best practice training (evidence-informed training design; effective delivery method; inclusive digital learning; support and accessibility; and strong leadership to foster long-term impact of training.) The guidance should make clear that this is necessary to comply with Regulation 36 of the guidance.

CARE INSPECTORATE WALES

Evidence of compliance with Regulation 36 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 Good Work Framework (or an equivalent level of an updated national framework) and is at 'Skilled Worker' level for all direct care staff working in older adults' care
- Training has been designed to meet the specific needs of the learners (using a tool such as a Training Needs Analysis tool)
- Training is evidence based - underpinned by evidence and that the provider is familiar with the evidence underlying the training
- Training represents the full diversity of lived experience of people with dementia, unpaid carers and staff

- Includes in-person training and/or interactive online training, mentoring and/or coaching
- Training includes at least eight-hours dementia specific training in delivery

Where care providers are found to not meet the above requirements for good quality dementia care, CIW must set out clear improvement measures and use its existing powers where necessary to drive improvement.

WELSH GOVERNMENT

The Welsh government should consider how to support providers to meet the new proposed requirement in the the relevant statutory guidance for care home and domiciliary support services issued under the Regulation and Inspection of Social Care (Wales) Act 2016. Levelling up from the current average training care workers receive to best practice training would be at an estimated cost of £72.32 per direct care worker working in older people's care, or a total of £2.8m. This total would cover both the cost of the training course (£0.8m) and the cost of staff time (£2m). There would be an approximate additional annual cost of £0.45m to train new starters.

RECOMMENDATIONS FOR CARE PROVIDERS, TRAINING LEADS AND STAFF

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

- Aligned to the 'Skilled Worker' level of the Good Work Framework (or an equivalent level of an updated national 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
- 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

REFERENCES

1. Care Council For Wales. Good Work: A Dementia Learning and Development Framework for Wales (2016) https://socialcare.wales/cms-assets/documents/Good-Work-Dementia-Learning-And-Development-Framework.pdf
2. Alzheimer's Society. Because We're Human Too: Why dementia training for care workers matters, and how to deliver it. 2024
3. Surr C, Gates C, Irving D, et al. Effective dementia education and training for the health and social care workforce: a systematic review of the literature. Review of Educational Research. 2017
4. Brunkert T, Simon M, Ruppen W, Zúñiga F. Pain Management in Nursing Home Residents: Findings from a Pilot Effectiveness-Implementation Study. Journal of the American Geriatrics Society. 2019;67(12):2574-2580. doi:10.1111/jgs.16148
5. Alzheimer's Society. Economic Impact of Dementia. 2024; Available from: https://www.alzheimers.org.uk/what-we-do/policy-and-influencing/economic-impact-of-dementia
6. Matthews, F.E., et al., A two-decade comparison of prevalence of dementia in individuals aged 65 years and older from three geographical areas of England: results of the Cognitive Function and Ageing Study I and II. Lancet, 2013(1474-547X (Electronic))
7. All-Party Parliamentary Group on Dementia. Workforce Matters: Putting People Affected by Dementia at the Heart of Care. 2022. https://www.alzheimers.org.uk/sites/default/files/2022-09/APPG%20on%20Dementia%20Workforce%20Matters%20Report%202022.pdf
8. Woods B, Rai HK, Elliott E, Aguirre E, Orrell M, Spector A. Cognitive stimulation to improve cognitive functioning in people with dementia. Cochrane Database of Systematic Reviews. 2023;(1)doi:10.1002/14651858.CD005562.pub3
9. Social Care Wales. Dementia care and support learning and development implementation toolkit. 2025. https://socialcare.wales/resources-guidance/improving-care-and-support/people-with-dementia/dementia-care-and-support-learning-and-development-implementation-toolkit
10. Surr C, Gates C, Irving D, et al. Effective dementia education and training for the health and social care workforce: A systematic review of the literature. Review of

Educational Research. 2017;87(5):966-1002.

11. Improvement Cymru. The All Wales Dementia Care Pathway of Standards – enabling improvements in the provision of dementia care for individuals and their carers, by Michaela Morris, Service Improvement Manager for Mental Health. 2021. https://www.improvementcymru.net/en/2021/03/23/the-all-wales-dementia-care-pathway-of-standards-enabling-improvements-in-the-provision-of-dementia-care-for-individuals-and-their-carers-by-michaela-morris-service-improvement-manager-for/

12. Welsh Government. The Regulation and Inspection of Social Care (Wales) Act 2016. 2016.

13. Smith SJ, Parveen S, Sass C, Drury M, Oyebode JR, Surr CA. An audit of dementia education and training in UK health and social care: a comparison with national benchmark standards. BMC Health Services Research. 2019/10/21 2019;19(1):711. doi:10.1186/s12913-019-4510-6

14. Surr, C., et al., A collective case study of the features of impactful dementia training for care home staff. BMC Geriatrics, 2019. (1471-2318 (Electronic))

15. Care Quality Commission. Health and Social Care Support for People with Dementia. . 2025. https://www.cqc.org.uk/publications/health-and-social-care-support-dementia

16. Skills for Care. A workforce strategy for adult social care in England. 2024. https://www.skillsforcare.org.uk/Workforce-Strategy/Recommendations-and-commitments/Train.aspx

17. Skills for Care. The state of the adult social care sector and workforce in England. 2025. https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/workforceintelligence/Reports-and-visualisations/National-information/The-State-of-report.aspx

18. Irving D, Oyebode J, Smith SJ, et al. Effective dementia education and training for the health and social care workforce: a systematic review of the literature. Review of Educational Research. 2017;87(5):966-1002. doi:10.3102/0034654317723305

19. Surr C. SS, Latham I., . Education and Training in Dementia Care: A person centred approach Open University Press; 2023.

20. Kaduszkiewicz H, Wiese B, van den Bussche H. Self-reported competence, attitude and approach of physicians towards patients with dementia in ambulatory care: results of a postal survey. BMC health services research. 2008;8:54-54. doi:10.1186/1472-6963-8-54

21. Newbould LA-O, Samsi KA-O, Wilberforce MA-O. Developing effective workforce training to support the long-term care of older adults: A review of reviews. (1365-2524 (Electronic))

22. Dow, B., et al., Promoting Independence Through Quality Dementia Care at Home (PITCH): An Australian Stepped-Wedge Cluster Randomised Controlled Trial Evaluating a Dementia Training Program for Home Care Workers. International Journal

of geriatric Psychiatry. 2024.(1099-1166 (Electronic))

23. Scerri A, Scerri C. Outcomes in knowledge, attitudes and confidence of nursing staff working in nursing and residential care homes following a dementia training programme. Aging and Mental Health. 2019;23(8):919-928. doi:10.1080/13607863.2017.1399342

24. Rokstad A, Døble BS, Engedal K, Kirkevold Ø, Benth JŠ, Selbæk G. The impact of the Dementia ABC educational programme on competence in person-centred dementia care and job satisfaction of care staff. International Journal of Older People Nursing. 2017;12(2):1-10. doi:10.1111/opn.12139

25. Fukuda K, Terada S, Hashimoto M, et al. Effectiveness of educational program using printed educational material on care burden distress among staff of residential aged care facilities without medical specialists and/or registered nurses: cluster quasi-randomization study. Geriatrics and Gerontology International. 2018;18(3):487-494. doi:10.1111/ggi.13207

26. Kaasalainen S, Hunter PV, Hill C, et al. Launching 'Namaste Care' in Canada: findings from training sessions and initial perceptions of an end-of-life programme for people with advanced dementia. Journal of Research in Nursing. 2019;24(6):403-417. doi:10.1177/1744987119832932

27. Annear, M.J., et al., Dementia knowledge assessment scale (DKAS): confirmatory factor analysis and comparative subscale scores among an international cohort. BMC Geriatrics. 2017. (1471-2318 (Electronic))

28. Schepers, A.K., et al., Sense of competence in dementia care staff (SCIDS) scale: development, reliability, and validity. International Psychogeriatrics. 2012(1741-203X (Electronic))

29. Skills for H, Health Education E, Skills for C. Dementia Training Standards Framework. 2018

30. Care Quality Commission. Regulations for service providers and managers (Regulation 18) 2008

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 Good Work: A Dementia Learning and Development Framework for Wales (2016).
- Training has been designed to meet the specific needs of the learners (using a tool such as a Training Needs Analysis tool).
- Training is evidence based - underpinned by evidence and that the provider is familiar with the evidence underlying the training.
- Training represents the full diversity of lived experience of people with dementia, unpaid carers and staff.
- Training includes in-person training, mentoring and/or coaching.
- Training includes at least eight 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 *Good Work: A Dementia Learning and Development Framework for Wales (2016).*

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

The DeTDAT audit tool is available here
https://www.leedsbeckett.ac.uk/-/media/files/research/dementia/dementia-education-and-training-audit-tool-v4.docx

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

STANDARD	DESCRIPTION	RECOMMENDATIONS / RESOURCES / HOW TO EVIDENCE THIS
Design content and materials		
Training maps onto the intended, relevant *Good Work: A Dementia Learning and Development Framework for Wales (2016)* level with clear learning objectives/ outcomes associated with the topics.	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 *Good Work: A Dementia Learning and Development Framework for Wales (2016)* includes a set of learning outcomes associated with each topic. A single training programme should not aim to cover all topics and all learning outcomes. Therefore, we recommend a training needs analysis is conducted to ensure learning outcomes are mapped appropriately to staff roles and needs.	Resources include *Good Work: Dementia learning and development framework for Wales.* The DeTDAT audit tool. Mapping tools should be used to evidence how training content relates to the *Good Work: A Dementia Learning and Development Framework for Wales (2016).* Learning outcomes that relate to the topics and framework should also be included in the learning materials.
Training has been designed for/ tailored to the specific service setting and job role of learners who will attend.	Training content and associated materials should be tailored to the service setting and role of the staff attending. If staff perceive the training is relevant to their role and the realities of day-to-day practice, they are more likely to be able and willing to implement it. The accessibility of training design and delivery should be considered, including the content, language and delivery methods, particularly if attendees may have low literacy skills, or English as a second or additional language. Training should not be generic or adopt a one-size-fits-all approach.	It is recommended to have specific training for direct care roles. Resources include Training Needs Analysis tools for dementia. Assessments of knowledge to understand levels of knowledge in staff. Collating feedback from staff / consultation with staff. Any information about staff knowledge or staff consultation should be retained as evidence (for regulators or commissioners) that training needs were assessed before the training was developed or delivered.
Training content covers all learning outcomes in a depth that is relevant to the Tier and learners' job roles.	In addition to which learning outcomes are covered, the depth of coverage is also important. Staff should have the opportunity, to cover all of the learning outcomes relevant to their role, in the required depth /at the required Tier. A brief mention of a topic, for example through inclusion via 1-2 bullet points on a slide, is likely to be insufficient to meet the depth and complexity of knowledge required to meet most of the learning outcomes in the *Good Work: A Dementia Learning and Development Framework for Wales (2016).*	Mapping exercises should consider the depth of training as well as the content.

STANDARD	DESCRIPTION	RECOMMENDATIONS / RESOURCES / HOW TO EVIDENCE THIS
Training includes interactive learning activities.	Training should be interactive, which might for example include discussion, group work, practical activities, experiential exercises, simulation, viewing videos, talks by carers and people with dementia, multi-media online content. This can support problem-solving and application of learning into practice. Predominantly didactic (talking to/at a group) training is unsatisfactory. Short periods of didactic content, within interactive learning is more appropriate. Individual learning via a written (paper or web-based) resource is ineffective for learning.	Training should include in-person elements to best meet these standard. If delivered online this should be interactive and facilitated by an experienced trainer.
Training includes group discussion.	Group discussion should be a core component of every training programme, since it aids learners to assimilate new information and to e work through complexities, ask questions and to discuss potential information barriers .	Training should include in person elements to best meet this standard. If delivered online this should be interactive and facilitated by an experienced trainer.
Training is evidence based and the provider is familiar with the evidence underlying the training.	Training should provide evidence based and rooted in a clear and established approach that is supported by evidence. For example, the *Good Work: A Dementia Learning and Development Framework for Wales (2016)* 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 information about how lived experience is included in the training – with documentation to support this e.g. learning materials.
Training includes learning activities that involve the application of what is learnt to a practice-based situation.	Training should include opportunities to apply learning in practice for example through training-based exercises, simulation, role play or in-practice activities that staff carry out between training sessions.	Training should include in person elements to best meet this standard. If using e-learning careful consideration should be given to how to entact this kind of practice based training sensitively and ethically.
Training materials are clear and easy to follow e.g. are jargon free, clearly laid out, take into account educational background of learners.	Materials need to be accessible, jargon free and written with their audience in mind, including considering the prior educational experience, English language competency/confidence, and literacy levels of learners.	This should be able to evidence 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 evidenced in a detailed a training plan that can be provided as as evidence for regulators and commissioners.
Facilitator		
Facilitator is experienced in the delivery/facilitation of training.	Training should be delivered by a skilled and experienced training facilitator. They should have good knowledge of the topic and be able to speak credibly about application into day-to-day dementia care practice. Skilled facilitators create a supportive and safe learning environment where staff feel comfortable to ask questions and can adapt the training content and delivery appropriately to meet the group's needs, whilst also ensuring core content delivery.	Providers should be able to provide further information on or evidence the experience and skills of the facilitators.
Evaluation		
Training has been evaluated for its acceptability/usefulness, and impact on staff knowledge, confidence and attitudes to dementia and care practice.	All training should be appropriately evaluated for its perceived acceptability/usefulness, and impact on learners' knowledge, skills, attitudes to people with dementia. Ideally evaluation should also include consideration of impact on learners' practice and on outcomes for people with dementia. However, we recognise these latter outcomes can be more challenging to evidence.	All training should be evaluated for its immediate impact on learners, providers should attempt to capture the impact of training on staff knowledge and skills, it is excellent practice to attempt to capture the impact of training on care practice (behaviour and results), through using methods such as observation (e.g. the PORT tool or Dementia Care Mapping).

APPENDIX C: FOR COMMISSIONS AND REGULATORS (SUCH AS CIW)

RESOURCES FOR EVALUATING THE QUALITY OF DEMENTIA TRAINING

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

- Training has been evaluated and has impacted on staff knowledge, confidence and attitudes to dementia and care practice (see supplementary materials for guidance on measuring training impact)
- Training has been mapped to the Good Work Framework , and is at least 'Skilled Worker' level 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 CIW should look for indicators of these considerations in assessing the quality of training as part of its inspection regime

CHOOSING THE EVIDENCE TO REVIEW

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

STANDARD	DESCRIPTION	RECOMMENDATIONS / RESOURCES / HOW TO EVIDENCE THIS
Design content and materials		
Training maps onto the intended, relevant Dementia Training Standards and is at least aimed at Skilled people with clear learning objectives/ outcomes associated with the topic and level.	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 *Good Work: A Dementia Learning and Development Framework for Wales (2016)* includes a set of learning outcomes associated with each topic. A single training programme should not aim to cover all topics and all learning outcomes. The individual topics, 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 *Good Work: Dementia learning and development framework for Wales*. Learning outcomes that relate to the topics 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 Level 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. 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 *Good Work: Dementia learning and development framework for Wales*.	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 on-line 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 *Good Work: A Dementia Learning and Development Framework for Wales (2016)* 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 in a training plan as evidence for regulators and commissioners.
Facilitator		
Facilitator is experienced in the delivery/facilitation of training.	Training should be delivered by a skilled and experienced training facilitator. They should have good knowledge of the topic and be able to speak credibly about application into day-to-day dementia care practice. Skilled facilitators create a supportive and safe learning environment where staff feel comfortable to ask questions and can adapt the training content and delivery appropriately to meet the group's needs, whilst also ensuring core content delivery.	Providers should be able to provide further information on or evidence the experience and skills of the facilitators.
Evaluation		
Training has been evaluated for its acceptability/usefulness, and impact on staff knowledge, confidence and attitudes to dementia and care practice.	All training should be appropriately evaluated for its perceived acceptability/usefulness, and impact on learners' knowledge, skills, attitudes to people with dementia. Ideally evaluation should also include consideration of impact on learners' practice and on outcomes for people with dementia. However, we recognise these latter outcomes can be more challenging to evidence.	All training should be evaluated for its immediate impact on learners, providers should attempt to capture the impact of training on staff knowledge and skills, it is excellent practice to attempt to capture the impact of training on care practice (behaviour and results), through using methods such as observation (e.g. the PORT tool or Dementia Care Mapping).

APPENDIX D: DETAILED COSTINGS

Estimates as to the current costs of training a care worker in Wales 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 Wales, we utilise the 2025/26 Real Living Wage rate (£13.45) as this is the minimum level of remuneration for job roles in social care in Wales. For cost of the training course, d_i, the cost for an external course is estimated from the reported external costs in the survey data. Average cost per external course is estimated as £1,864.14 (95% confidence interval: £495.20-£3233.10).

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

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

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.

oped course have been delivered. From the survey data, the average course had been delivered 258.3 times (95% confidence interval: 55.8-460.9). This gave an average *development cost* per session of £4.62.

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

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

AVERAGE COST OF DEMENTIA TRAINING

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

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

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.

estimate of proportion trained, assuming it was constant across countries. For Wales, this was all care workers and senior care workers employed in residential care and home care from Social Care Wales (2024).

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 *Good Work: A 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=13).

TABLE 1

Topics covered by the Good Work: A Learning and Development Framework

30 training packages reviewed: 26 dementia-specific · 4 with a dementia component. Sorted by frequency within group. Percentages reflect proportion of packages covering the topic.

TOPIC	TOTAL N=30	%	DIMENTIA-SPECIFIC N=26	%	WITH DEMENTIA COMPONENT N=4	%
AWARENESS **DEMENTIA AWARENESS & COMMUNICATION**						
Being a Dementia Friend (dementia awareness and communication)	**10**	33%	**10**	38%	0	0%
WELL-BEING **GOOD WORK FRAMEWORK — WELL-BEING THEMES**						
Physical environment	**26**	87%	**22**	85%	4	100%
Physical and mental health	**35**	83%	**21**	81%	4	100%
Meaningful living	**25**	83%	**22**	85%	3	75%
Safeguarding	**23**	77%	**20**	77%	3	75%
Community inclusion and contribution	**23**	77%	**20**	77%	3	75%
Rights and entitlements	**21**	70%	**18**	69%	3	75%
Meaningful relationships	**21**	70%	**18**	69%	3	75%
Social and economic well-being	**20**	67%	**17**	65%	3	75%

TABLE 2

Level at which social care staff have received dementia training

n=44 social care staff surveyed. Wales only. Sorted by frequency. Respondents may report multiple training routes.

TRAINING ROUTE	COUNT OF 44	% OF RESPONDENTS
TOTAL RESPONDENTS	**44**	—
Dementia awareness	38	**86%**
Dementia training as part of induction [c]	28	**64%**
Dementia-specific training	28	**64%**
Dementia training as part of formal qualification (NVQ or degree)	18	**41%**
Care Certificate [c]	14	**32%**
Other	4	**9%**

[c] The Care Certificate is recognised as an indicator of competence in England; figures for Wales should be interpreted with caution.

TABLE 3

Barriers to training

% of 13 providers (multi-select). Sorted by frequency. Italicised rows are summary aggregates.

BARRIER	N	%
Geography / distance to travel	5	38%
Direct costs of training	4	31%
Unable to release staff	4	31%
Have not experienced any barriers	4	31%
High staff turnover	3	23%
Support from management	2	15%
Lack of staff engagement / interest	2	15%
Access to digital devices / technology	1	8%
Language and/or cultural needs of staff	1	8%
Staff morale / burnout	1	8%
Lack of suitable training	1	8%
Training outside paid hours without remuneration	0	0%
Access to appropriate space for training	0	0%
Access to mentors	0	0%
Other	0	0%
Don't know	0	0%
SUM: Financial factors	4	31%
SUM: Access to resources	1	8%
SUM: Staff attitude	5	38%

TABLE 4

Facilitators of training

% of 13 providers (multi-select). Sorted by frequency. Italicised rows are summary aggregates.

FACILITATOR	N	%
Support from management	10	77%
Positive staff engagement	7	54%
Positive cultures of care	6	46%
Skilled and experienced facilitator	5	38%
Designated training lead / dementia champions	5	38%
Technology	4	31%
Direct costs for training supported	3	23%
Renumeration for staff outside paid hours	3	23%
Group-based learning	3	23%
Access to space for training	3	23%
Ring-fenced tim	2	15%
Protected time to reflect	2	15%
Staff incentives	1	8%
Nothing has helped	1	8%
Adaptability to language or cultural needs of staff	0	0%
Other	0	0%
Don't know	0	0%
SUM: Financial factors	7	54%
SUM: Access to resources	7	54%
SUM: Staff attitude	17	131%


LBU
LEEDS
BECKETT
UNIVERSITY


Alzheimer's
Society
Cymru
Bydd yn cymryd cymdeithas i guro dementia
It will take a society to beat dementia


IFF Research