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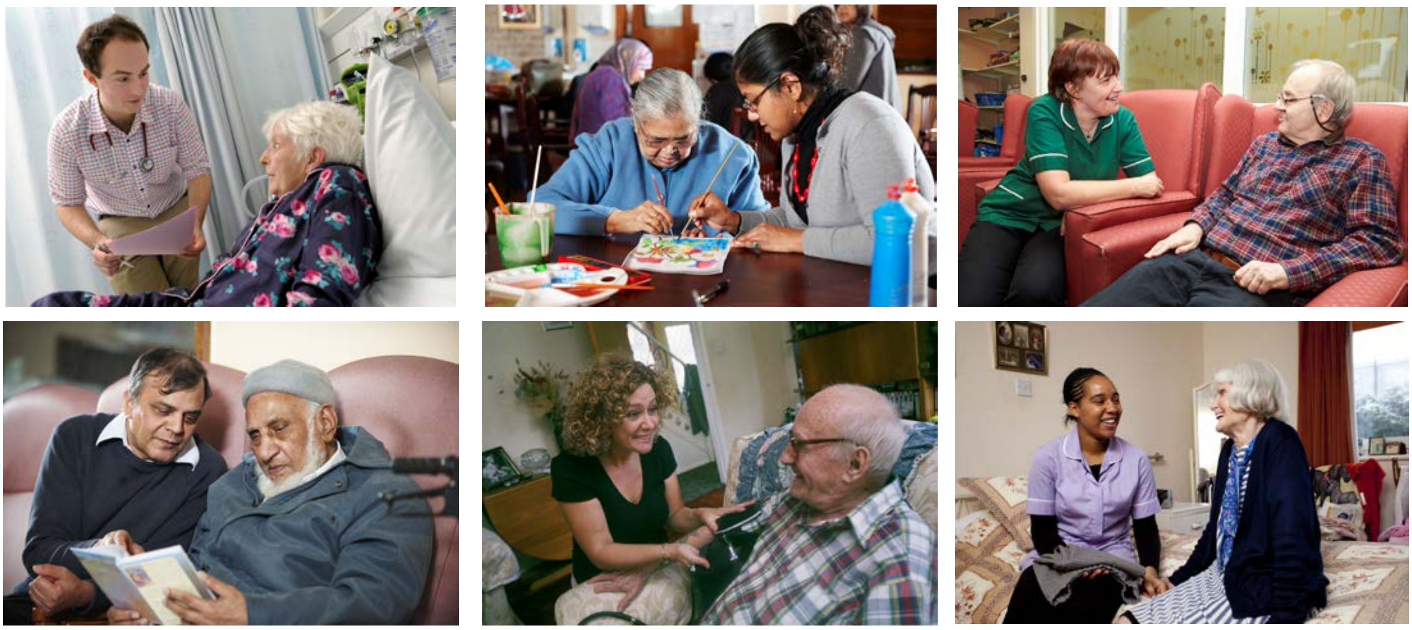
Dementia Academic Action Group Dementia Awareness Training Project Report



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Contents

Executive Summary

The following summarises the development, implementation, and evaluation of a multi-phase, two-year project undertaken by the Dementia Academic Action Group (DAAG). Initially the project scoped what dementia training was currently being delivered within the Thames Valley region at Tier 1, with a view to informing the development of a coordinated approach to on-going and future dementia training in this region. This report briefly presents the aims and objectives, the methods, key findings and outcomes of the three phases of the project.

Background

The increase in the incidence and prevalence of dementia has resulted in the need for major improvements in dementia care, training and health and social care policy and practice in the United Kingdom (WHO, 2012, NICE, 2006, Department of Health [DH], 2009; DH, 2015).

Recent government reports such as the National Dementia Strategy (2009), the National Audit of Dementia (2010), the Prime Minister, David Cameron's, Dementia Challenge (2012) and the G8 Dementia Summit Declaration (2013) have all highlighted the need to improve the quality of dementia care provision in a manner which is cost effective yet easily accessible to all who may need it.

Developments in health and social care policy mean there is a raised expectation that the health and social care workforce will be able to rise to the challenge of providing high quality dementia care. Whilst it is appropriate and indeed necessary for the improvement of dementia care delivery, it is essential for the health and social care workforce to be educated, informed and equipped to provide high quality care at whatever stage of the disease process.

Figure 1: Thames Valley Region – Local Authority Boundaries

Source: Adapted from www.bma.co.uk

It is against this background that the Department of Health issued the Delivering High Quality, Effective, Compassionate Care Mandate to Health Education England (DH, 2014) stipulating that the NHS is responsible for ensuring that 85% of staff undertake dementia awareness training at Tier 1 Level and more recently the Prime Minister, David Cameron's, Challenge 2020 aims to ensure that all NHS staff are trained 'on dementia appropriate to their role' (DH, p.37, 2015b).

As part of Health Education England's response to the 2014 Mandate, Health Education England Thames Valley (HEE TV) commissioned a collaboration of four Higher Education Institutions to undertake this multi-phase project. University of West London, Oxford Brookes University,

University of Bedfordshire and University of Northampton hence became partners in the Dementia Academic Action Group (DAAG).

Methods

Phase 1: The Scoping Review

Phase 1 of the project, which was launched in April 2014, had five objectives, which were to:

1. Review current dementia training at Tier 1 within the Thames Valley region;
2. Identify gaps within the current training provision;
3. Identify the needs of the health sector to inform future dementia training provision;
4. Identify examples of best practice within the current training provision to inform future dementia training provision;
5. Analyse national and local policy concerning dementia awareness in order to inform training provision.

A multi-method qualitative approach was employed in order to achieve a comprehensive understanding of the range of dementia training currently being accessed in the Thames Valley region and to understand what issues healthcare organisations were facing in accessing this training. The chosen methods were:

- a literature review
- a review of Tier 1 educational resources (59 documents at Tier 1)
- individual interviews with stakeholders (n=32)
- focus groups with carers (n=2)
- an online survey with staff (n=74)
- a critical discourse analysis of policy

Each Higher Education Institution (HEI) undertook a scoping review, stakeholder interviews and policy review for an identified geographical area in order to ensure both comprehensive coverage and to minimise any risk of duplication in contacting organisations. The literature review and focus group interviews were completed by the University of Northampton. The project team focused primarily on the health organisations, but the final data does include some input from wider social care and community-based organisations such as local authorities, police, fire brigade, and businesses. A total of 367 individual contacts were made during the course of this phase, with 353 different organisations contacted across the Region.

For the desk based scoping review, the focus was awareness training and training delivered at Tier 1, although more advanced or specialist training was also identified. A website search and requests for documentation and curriculum data was made for review by the research team from a range of different sectors and providers. The types of organisations were:

- NHS Trusts;
- Local authorities;
- Dementia charities;
- Higher/further education;
- Private training providers.

In addition, government websites and other relevant online sources were reviewed to identify training provision delivered locally and nationally. A total of 97 training resources were identified, of which 59 were identified to be at Tier 1. A matrix of training programmes against key training deliverables was mapped by each University and was input into a master matrix by the University of Northampton.

A bibliography of documentation and resources identified during this stage has been created, listing the source of the training and title (see full report).

Thirty-two stakeholder interviews (n=8 by each HEI partner) were undertaken. All were completed with Local Authorities, Community Health Care Services, Acute Hospital Trusts, GP practices, Care Homes and Domiciliary services and representations from dental practice, pharmacy and ambulance services. The interviews explored issues around types and range of dementia training, gaps in the current provision, subject areas which should be covered by future training, personnel (type and level of role), access to training, knowledge of dementia awareness policy and areas of best practice.

An online questionnaire was developed to explore the views and experiences of staff, across a range of organisations, about their awareness of dementia issues, how their organisation may promote awareness of dementia, the dementia training they have may have accessed and what, if any, training they would like to access. Organisations (n=261) were asked to distribute the survey, and 74 respondents returned completed questionnaires. A separate online survey was developed to recruit general practice (GP) doctor participants into this phase of the project. A total of nine participants were recruited via an ex-carer group called Qualified by Experience (QBE) and the Alzheimer's Society UK Research Network who took part in focus groups, in which their lived experiences of caring for a person living with dementia, the extent of their knowledge acquisition relating to dementia care; and their perceptions of the level of knowledge and skills demonstrated by the formal carers of their loved ones was discussed.

A desk based literature search of academic and grey literature was conducted to identify current best practice in this area, obvious gaps in the provision of training, and preferred delivery methods and styles. Further to this, the literature review provided the context for training in dementia and identified future considerations for the development and delivery of Tier 1 training packages. To ensure the outputs of the search were manageable within the scope of the project searches were targeted to publications completed between 2004 and 2014 (one decade), with a focus on those published from 2009 onwards, in alignment with the National Dementia Strategy.

Finally, a critical discourse analysis of national and local dementia policy was completed to understand the implications of dominant discourses underpinning dementia policy for dementia training. Each partner identified the local policies relevant to their region of Thames Valley. Aspects of the policy specifically related to dementia were charted and a comparative analysis was completed.

Data obtained via individual stakeholder and focus group audio-recorded interviews were transcribed verbatim and analysed thematically. A data analysis matrix was developed for the interview analysis, this was developed to identify key themes in the data and ensure the analysis process was reliable and robust. Data from the focus groups was thematically analysed using the software package NVivo and key themes identified. Data from the online questionnaire was transferred into the Statistical Package for the Social Sciences (SPSS) for analysis. Descriptive statistical analysis was conducted to identify key trends in the data and open-ended questions were analysed thematically. Data from the scoping review was entered into a matrix, to identify the key learning outcomes of the training which were then mapped against the Dementia Competency Framework as developed by South West Dementia Partnership and the Tier 1 Dementia Awareness Competencies as created by London Dementia Strategic Clinical Network. The data was entered into SPSS for descriptive analysis of the emergent themes.

The project was approved by the University of Northampton's Research Ethics Committee and this approval recorded by each HEI's Research Ethics Committee to ensure best practice ethical guidelines were adhered to. Governance approval was also sought from participating NHS Trusts, through the Research and Development teams.

This first phase of the project concluded in November 2014 with the publication of the Dementia Academic Action Group Dementia Awareness Training Report (2014) which was disseminated to key stakeholders within the Thames Valley Region by means of a

Stakeholder Event that was hosted by Health Education England Thames Valley in December 2014.

Phase 2: Developing and delivering the Tier 1 Training Packages

Phase 2 of the project, the development and delivery of the training packages, began in January 2015. The objectives for this phase of the project were to:

1. Use the findings from Phase 1 to inform the planning and delivery of Tier 1 training;
2. Identify areas where there are gaps and variation in training delivery and develop a strategy in order to address these to improve quality;
3. Develop free to use Tier 1 dementia awareness training packages aligned with Skills for Health dementia curricula, providing a sustainable resource for HEE TV.

The training packages were developed and piloted prior to full scale delivery which commenced on the 11th May 2015 and was completed by the 11th December 2015. The packages were in two formats ‘standard’ (2 hours) and ‘enhanced’ (this was an additional hour, on top of the two hour standard package). The intent of the designers was to learn from the scoping undertaken in Phase 1 and from the existing training materials and packages by replicating those elements that clearly worked, whilst supplementing these with identified gaps to create a new product that was based on the current available evidence. The scoping review had suggested that despite the range of training being delivered for health and social care staff, there remained some areas where training was not focused or having an impact into practice. It identified gaps and barriers that needed to be considered in the design of the training materials, which included:

- Early diagnosis and recognition of symptoms;
- Understanding of the different types of dementia;
- Pharmacological treatments;
- Application and principles of person centred care;
- Communication;
- Understanding ethical issues and principles;
- Young people with dementia;
- Cultural issues;
- Time to be made available for training;
- All staff should receive training.

The scoping review also highlighted a wide range of existing packages already in use in the UK using many different delivery mechanisms, from formal classroom settings to complete online delivery. The main recommendation for delivery style was:

- A flexible and blended learning approach to the delivery of training would be most suitable for the health care services.
- An approach which offers short sessions, to accommodate staff availability, uses a mixture of face-to-face, eLearning, video, exercise etc. and one which can be tailored to the staff attending was identified as being suitable.

The designers therefore opted for a blended package design that included didactic components, discussions, reflection, use of videos and access to online resources. Flexibility could be achieved through the insertion of different videos to suit particular audiences. However, a SCIE video, in which people with dementia describe their experience of dementia, was chosen as a core component to represent the voice of people living with dementia, and their carers. Flexibility could be achieved through the insertion of different videos to suit particular audiences. However, in the first instance the aim was to create a generic package that would deliver Tier 1 learning outcomes, regardless of the nature of the audience: in other words, it should not appeal to a particular professional group, but appeal to all. It was also not designed to go beyond the Tier 1 learning outcome and should be seen to be a starting point for most of the audience, whilst still functioning as a refresher and/or update for those who already had significant experience and knowledge of dementia.

A stakeholder event in January 2016 provided feedback about the delivery of the training and how to develop the current training model into a sustainable training package, accessible to health and social care organisations across Thames Valley. The final stage of the project was to then revise the training materials into this sustainable package.

The DAAG has developed evidence based and quality assured training based on recognised national standards such as Skills for Health Dementia Training Standards (2015). The content training packages which have been developed have built on the key findings from Phase 1 of the project, together with being mapped against the core skills and has been delivered face-to-face to an inter-professional audience, which included clinical and non-clinical staff. Over 1,400 health and social care staff were trained by a total of four facilitators. Challenges that were faced, including the cost of releasing staff and also meeting organisational needs have been highlighted and suggestions for the future sustainability of this training have also been identified, which together with the findings from Phase 3 of the project, will form the conclusions and recommendations at the end of this summary.

Phase 3: Evaluation of Tier 1 dementia awareness training packages

Phase 3 was launched at the same time as Phase 2, in January 2015 and was completed by April 2016. The objectives of this phase were to:

1. Evaluate the pre and post knowledge of training attendees;
2. Evaluate the use of the training in practice;
3. Use the evaluation of Phase 2 of Tier 1 dementia awareness training to inform future dementia training provision.

The evaluation aimed to provide participants' feedback on the feasibility, applicability and usefulness of the programme from the perspective of participants immediately following the training activity, and again at six weeks.

Data was collected for the time period of active training delivery (May 2015- Jan 2016) to facilitate the following metrics:

1. The numbers of training sessions offered;
2. The number of training sessions delivered;
3. The numbers of staff attending sessions;
4. Participant's self-reported measures of their knowledge, attitude and confidence in caring for people living with dementia and their carers;
5. Participants' self-reported changes to practice as a result of attending training.

Evaluation data were collected via the application of a pre and post training validated questionnaire using a Likert-type scale which analysed of participants' self-reported changes in knowledge, attitude and confidence in working with people with dementia (see full report). A further post-training questionnaire was sent six weeks following the initial training to evaluate participants' application of learning in the workplace (see full report). This included the identification of participants' perceptions of organisational barriers and facilitators. The Likert scale is an ordinal psychometric measurement of attitudes, beliefs and opinions (Likert, 1932), which is commonly used in educational evaluation.

In addition, telephone interviews were conducted with participants who expressed a willingness to participate further in the evaluation to examine if there was anything that should have added or omitted from the training content (see full report).The telephone interviews explored individual and organisational barriers and facilitators in transferring training to practice. Each participating university was scheduled to undertake up to 16 telephone interviews to include eight clinical and eight non-clinical participants. Each interview was scheduled to last approximately 15 minutes on advice from colleagues within NHS Trusts. Interviews were digitally recorded to enable reporting of verbatim comments from participants. In order to limit bias, the interviews were not conducted by the person who had delivered the training event.

Quantitative data from the questionnaires were cleaned and double entered into SPSS (version 23) for analysis. Two key outcome measures were defined as participants' knowledge about dementia before and after the training and participants' changes in attitude, skills and confidence in working with people with dementia as a result of the training. Frequencies were calculated for all measures; clinical/ non-clinical staff who did or did not have contact with people with dementia and employing organisations were cross-tabulated with knowledge, skills and attitude items. Parametric tests were used to perform analyses on responses measured by a Likert scale (Sullivan & Artino, 2013); independent t-test, chi-square test for independence and one-way ANOVA were used to assess statistical significance among variables. Qualitative data obtained via the evaluation questionnaire and semi-structured telephone interviews was analysed using predetermined thematic analysis.

The University of West London, College of Nursing Midwifery and Healthcare Research Ethics Committee approved the evaluation phase of the DAAG project. In addition, each partner university submitted the UWL documentation internally for governance purposes.

Overall participants evaluated the standard training package positively. Quantitative data provided information on who had received the dementia training and the impact of the training on the participants; qualitative data provided further insight of participants' experiences of the training and how they had transferred knowledge into practice. Training was delivered across all staff groups and included clinical and non-clinical staff from the organisations that engaged with the DAAG project. More than 50% of participants had not received any previous dementia training and therefore the programme facilitated the achievement of nationally set targets for Tier 1 dementia training.

The quality of the training and the use of a multidisciplinary and blended learning approach were perceived positively by participants. The training materials were considered to be highly relevant, with the use of video material having a significant emotional impact on participants' insight into the impact of dementia on the lives of individuals and their carers.

The immediate impact of the training on the knowledge and skills of participants indicated that there was a self-reported increase in the level of knowledge participants gained from the programme. Our analysis identified no significant differences between clinical/ non clinical staff or professional categories or employing organisations. Over 85% of respondents reported improved skills, attitudes and confidence in working with people with dementia following the training. Of note is that healthcare assistants and participants working in care homes reported higher levels of knowledge on several aspects of dementia compared to participants with other job roles and working in other settings.

The response to the six-week follow-up questionnaire provided some insight into the intermediate impact of training. While the number of respondents returning the questionnaire was somewhat low (131 [12.4%]) of those who did respond 70.2% indicated that they had been able to transfer some of what they had learned in the training to practice. Those participants who indicated that they were not able to apply knowledge in their job roles identified that this was because they had not had any contact with people with dementia or their carers since the training event and hence, had not had any opportunities to apply their knowledge in their job duties. This is an important issue for employers as training is known to decay over time and has greater impact when participants are able to practice what they have learned in order to embed new behaviours.

Telephone interview respondents provided examples of how and when they would use what had been learnt; in addition they were aware of the impact of the training on their job roles and their personal lives. Most participants highlighted the importance of incorporating dementia training as part of an induction programme and emphasised the need for refresher events to update new information and services available for people with dementia.

Conclusions: Future directions

The central aim of this DAAG awareness (Tier 1) training project was to review what was currently being delivered in the HEE TV region with a view to informing the development of a coordinated approach to on-going and future dementia training in this area. To that end, the DAAG project team have reviewed both the availability of training resources in the region and local and national policy implications for the delivery of dementia awareness training; and based on those findings, they have developed training packages which have been evaluated as ‘fit-for-purpose’.

The final phase of the project was to finalise the sustainable model for the delivery of Tier 1 dementia awareness training across the HEE TV region. Following the feedback from the stakeholder events, trainees during training sessions, the evaluation and the Phase 1 review, the DAAG have developed the existing training into eight bite size units which could be delivered as a whole package (Units 1-6) or could be delivered individually. Each unit is approximately 30 minutes in duration and encompasses a variety of learning styles and formats, including: videos, discussion points and interactive learning. The units cover the following topics:

- Unit 1: What do you know about dementia?
- Unit 2: What dementia means?
- Unit 3: Understanding the person with dementia
- Unit 4: How does dementia affect the person and those around them?
- Unit 5: Talking and listening to the person with dementia
- Unit 6: Supporting people to stay well
- Unit 7: Living well in society
- Unit 8: How to respond to behaviours that challenge

A train the trainer programme with teaching manual and resources has been produced to enable organisations to deliver the training through peer to peer training. Units 1 and 8 have been designed to be delivered face-to-face as these units are the most interactive and learning from these units is better suited to being supported by a trainer. This also builds on the findings of the project that face-to-face learning is the preferred style and also is thought to provide opportunities for inter-disciplinary engagement across staff roles and responsibilities, enhancing learning opportunities further. However, an online version of the training has also been made available for those staff who are not able to attend a face-to-face training session but are still required to undertake Tier 1 dementia awareness training.

1 Introduction and aims

The purpose of this report is to present the outcomes of The Dementia Academic Action Group (DAAG), a collaboration of University of Northampton, University of Bedfordshire, University of West London and Oxford Brookes University. This multi-phase, two-year project was commissioned by Health Education England Thames Valley (HEE TV) following Health Education England's response to the Department of Health's mandate to ensure NHS staff are trained in dementia awareness training at Tier 1 foundation level.

This report presents the findings of the three phases of the project, which sought to scope the extent of Tier 1 (foundation level) dementia training being delivered within the Thames Valley region, in order to inform the development and delivery of training across the region and provide a coordinated approach to on-going and future training in the region.

1.1 Background

The increase in the incidence and prevalence of dementia has resulted in the need for major improvements in dementia care, training and health & social care policy and practice in the United Kingdom (WHO, 2012, NICE, 2006, Department of Health [DH], 2009; DH, 2015).

Recent government reports such as the National Dementia Strategy (2009), the National Audit of Dementia (2010), the Prime Minister, David Cameron's Dementia Challenge (2012) and the G8 Dementia Summit Declaration (2013) have all highlighted the need to improve the quality of dementia care provision in a manner that is cost effective yet easily accessible to all who may need it.

Figure 1: Thames Valley Region – Local Authority Boundaries

Source: Adapted from www.bma.co.uk

Such developments in health and social care policy mean there is a raised expectation that the health and social care workforce will be able to rise to the challenge of providing high quality dementia care. Whilst it is appropriate and indeed necessary for the improvement of dementia care delivery, it is essential for the health and social care workforce to be educated, informed and equipped to provide high quality care at whatever stage of the disease process.

It is against this background that the Department of Health issued the Delivering High Quality, Effective, Compassionate Care Mandate to Health Education England (DH, 2015a) stipulating that the NHS is responsible for ensuring that 85% of staff undertake dementia awareness training at Tier 1 Level and more recently the Prime Minister, David Cameron's, Challenge 2020 aims to ensure that all NHS staff are trained ‘on dementia appropriate to their role’ (DH, p.37, 2015).

As part of Health Education England’s response to the 2014 Mandate, Health Education England Thames Valley commissioned a collaboration of four Higher Education Institutions to undertake a multi-phase project which was launched in April 2014. University of West London, Oxford Brookes University, University of Bedfordshire and University of Northampton hence became partners in the Dementia Academic Action Group (DAAG).

The project was launched in April 2014 with Phase 1 concluding in November 2014 with the publication of the Dementia Academic Action Group Dementia Awareness Training Report (2014) which was disseminated to key stakeholders within the Thames Valley Region by means of a Stakeholder Event that was hosted by Health Education EnglandThames Valley in December 2014.

Phases 2 and 3 were launched in January 2015 with the development of a Tier 1 training package, which was piloted in May 2015. Training to health and social care professionals was then delivered and evaluated to December 2015. A stakeholder event run in January 2016 provided feedback about the delivery of the training and how to develop the current training model into a sustainable training package, accessible to health and social care organisations across Thames Valley. The final stage of the project was to then revise the training materials into this sustainable package.

1.2 DAAG aims and objectives

The overall aim of the project was to inform the development of a coordinated approach to Tier 1 dementia awareness training for the health social care workforce within Thames Valley.

Phase one objectives were to:

1. Review current dementia training at Tier 1 within the Thames Valley region;
2. Identify gaps within the current training provision;
3. Identify the needs of the health sector to inform future dementia training provision;
4. Identify examples of best practice within the current training provision to inform future dementia training provision.
5. Analyse national and local policy concerning dementia awareness in order to inform training provision.

Phase two objectives were to:

1. Use the findings from Phase 1 to inform the planning and delivery of Tier 1 training;
2. Identify areas where there are gaps and variation in training delivery and develop a strategy in order to address these to improve quality;
3. Develop free to use Tier 1 dementia awareness training packages aligned with Skills for Health dementia curricula, providing a sustainable resource for HEE TV;

Phase three objectives were to:

1. Evaluate the pre and post knowledge of training attendees;
2. Evaluate the use of the training in practice;
3. Use the evaluation of Phase 2 of Tier 1 dementia awareness training to inform future dementia training provision.

The project concludes with a revised training package which will be deliverable through a train the trainer programme or is available online as a free resource.

1.3 Core skills criteria for Tier 1

At the start of the project, the Tier 1 dementia awareness learning outcomes were still in the process of undergoing consultation and not yet agreed nationally. Two key documents were used to outline the dementia competencies for Tier 1 Dementia Awareness. These were:

- South West Dementia Partnership (2014) Dementia Competency Framework.
- London Dementia Strategic Clinical Network (2014) Guide to Dementia Training for Health and Social Care Staff in London Improving quality of care.

The competencies identified in these documents were used to map against the dementia training reviewed in the first phase of the DAAG project. This also formed the basis of the development of the training package delivered in Phase 2.

In October 2015, Health Education England released the standards in the document ‘Dementia Core Skills Education and Training Framework’ (SfH, EE & SfC, 2015). This Framework was commissioned and funded by the Department of Health and developed in collaboration by Skills for Health and Health Education England in partnership with Skills for Care. The Framework formally identifies dementia training across three tiers and states the learning outcomes at each of these tiers. The tiers are defined as:

- Tier 1 – dementia awareness for all health and care staff
- Tier 2 – knowledge and skills for those who have regular contact with a person living with dementia
- Tier 3 – enhanced knowledge and skills for experts working with people living with dementia

The definition of Tier 1 training has been identified as:

‘Raising dementia awareness, in terms of knowledge, skills and attitudes for all those working in health and care settings’

(Skills for Health, p.11, 2015).

1.4 Report structure

This report is structured to provide a full account of the way the DAAG was developed, delivered and evaluated. There is a separate section for each phase of the project which details the processes undertaken, how the project met current thinking and policy in dementia training and discusses the impact of the training.

The final sections of the report draws together the conclusions from each phase and considers the recommendations for the future delivery of Tier 1 training. The report also discusses the development of a final, revised training package which has been developed from the learning from each of the phases and provides a sustainable, free resource for health and social care professionals to access through an online resource or train the trainer sessions.

2 Phase 1: Review of dementia awareness training

2.1 Review methods

This section outlines the multiple methods approach adopted in undertaking the initial six month scoping review which was the first phase of a 24 month project. The approach was selected in order to achieve a comprehensive understanding of the range of dementia training currently being accessed in the Thames Valley region and to understand what issues healthcare organisations were facing in accessing this training. A multi-method qualitative approach was employed, consisting of a literature review; a review of Tier 1 educational resources (59 documents at Tier 1); individual interviews with stakeholders (n=32); focus groups with carers (n=2); an online survey with staff (n=74) and a critical discourse analysis of policy.

Each Higher Education Institution (HEI) partner (University of Bedfordshire, University of West London and Oxford Brookes University and University of Northampton) undertook a scoping review, stakeholder interviews and policy review for an identified geographical area in order to ensure both comprehensive coverage and to minimise any risk of duplication in contacting organisations. A detailed contact list of all organisations approached was centrally held, shared, and updated regularly by all HEI partners. The literature review and focus group interviews were completed by the University of Northampton.

Initially, the scope of this first phase of the project had been to focus on health organisations and wider social care and community-based organisations such as local authorities, police, fire brigade, and businesses. However, in discussions with the Commissioners, and informed by directives from Health Education England, this was reviewed during the course of the project. The revised brief was, to focus primarily on the health organisations. The data therefore does include some input from these wider organisations, but the emphasis of the report is on health care organisations. A total of 367 individual contacts were made during the course of this phase, with 353 different organisations contacted across the Thames Valley Region. While every effort has been made to capture the full range of training which is being delivered regionally, this is not an exhaustive list and the process of identifying training resources will continue throughout the whole project.

2.1.1 Scoping review

A primarily desk based scoping review was undertaken to identify the current dementia training provision within the Thames Valley area (and relevant national training provision); this focused on awareness training and training delivered at Tier 1, although more advanced or specialist training was also identified. It should be noted that members of the team also attended training days and completed online training as part of this review. A website search and requests for documentation and curriculum data was made for review by the research team from a range of different sectors and providers. The types of organisations were:

- NHS Trusts;
- Local authorities;
- Dementia charities;
- Higher/further education;
- Private training providers.

In addition government websites and other relevant online sources were reviewed to identify training provision delivered locally and nationally.

A total of 97 training resources were identified, of which 59 were identified to be at Tier 1. The review compares these documents for common practice and areas where the content and format differs, such as: study topics, time and style/method of training delivery, use of PPI engagement and aims and outcomes of the training. A matrix of training programmes against key training deliverables was mapped by each University and was input into a master matrix by the University of Northampton.

A bibliography of documentation and resources identified during this stage has been created, listing the source of the training and title.

2.1.2 Stakeholder interviews

It was proposed that 32 interviews would be undertaken, eight by each HEI partner. All 32 interviews were completed with the following organisation sectors: Local Authorities, Community Health Care Services, Acute Hospital Trusts, GP practices, Care Homes and Domiciliary services and representations from dental practice, pharmacy and ambulance services.

Not all of the organisations contacted were able or willing to take part in an interview. This was due to a number of factors including: access, declined to participate, lack of response to requests, identification of the correct individual and governance approval. It was not possible to speak with representatives from some of the organisations contacted and there was a sense from some that there was some wariness to take part in this study about how participation would be reported with regard to the meeting training targets. Where this was encountered, the team allayed any concerns and clarified the purpose of the review.

Each interview lasted approximately 45mins to one hour and was based on a discussion guide developed by the team, in collaboration with the commissioners. The interviews explored issues around types and range of dementia training, gaps in the current provision, subject areas which should be covered by future training, personnel (type and level of role), access to training, knowledge of dementia awareness policy and areas of best practice.

An invitation letter or email was sent to potential participants to inform them about the research. Contact details were identified by the commissioners, each HEI team, and via website searches. Interviews were arranged at a time and place to suit the participants, or were conducted via the telephone, if preferred by the participant. Subject to participant’s permission, interviews were fully audio-recorded, allowing reports to include verbatim comments from participants.

2.1.3 Online staff survey

An online questionnaire was developed by the project team, and in consultation with the commissioner, to explore the views and experiences of staff, across a range of organisations, about their awareness of dementia issues, how their organisation may promote awareness of dementia, the dementia training they have may have accessed and what, if any, training they would like to access. The questionnaire included a combination of open ended questions and ‘tick box’ questions, including demographic and geographical location questions and questions on barriers to or facilitators to accessing training.

The questionnaire was distributed by each HEI using email contact data developed through contacts made via the scoping review, stakeholder interviews, and through local knowledge. Telephone contacts were also used to ask key organisations to be involved in the online survey and to distribute this. This process was also helpful in identifying issues related to training delivery and possible contributions to the wider project. A unique link to the online questionnaire was provided with an introductory email to explain the purpose and nature of the questionnaire, how the results will be used and a contact number for further information.

The online questionnaire was developed and hosted using Bristol Online Survey software and was thoroughly tested, piloted, and signed off by the commissioners and project committee before ‘going live’. In total, 261 organisations were contacted to distribute the survey, of these most reported to be happy to send to their staff, however a total of 74 respondents returned completed questionnaires, suggesting limited distribution of the form by some organisations or difficulties encountered in accessing the online form. Some barriers or hesitation to participate in this part of the review was observed by the project team and there were a number of those contacted (n=18) who expressed overt reluctance to participate in the survey, one of which was due to already being involved in another dementia survey from a different organisation. Others, usually service providers who were part of a larger organisation, were not interested as they claimed that staff training was arranged through their national or regional Head Quarters, and therefore this was not something they dealt with locally. Other limitations to this approach were identified during the scoping phase, where the team became aware that not all NHS staff had access to work emails or computers and so would not be able to access the survey.

Cold calling organisations prior to sending the online survey or requests for training information proved useful at gaining additional insights into the barriers and enablers for training and for gaining buy-in for participation in the scoping review. For example it became apparent that in some larger organisations, people who were each involved in delivering dementia training were not necessarily aware of each other’s existence.

2.1.4 Carer focus groups

A total of nine participants attended two carer focus group sessions. Participants were recruited via an ex-carer group called Qualified by Experience (QBE) and the Alzheimer’s Society UK Research Network.

Each group was arranged at a suitable time and venue for the participants and lasted approximately one hour. A discussion guide was designed by the project team and agreed with commissioners in advance. The groups were led by an experienced independent facilitator, who explored the participant’s former ‘lived’ experiences of caring for a person living with dementia, the extent of their knowledge acquisition relating to dementia care; and their perceptions of the level of knowledge and skills demonstrated by the formal carers of their loved ones. The interviews were audio-recorded and transcribed verbatim, allowing for the inclusion of verbatim comments from participants in this report.

2.1.5 Literature review

A desk based literature search (see Table 1 for search criteria), of academic and grey literature, was conducted to identify current best practice in this area, identified gaps in the provision of training, and preferred delivery methods and styles. Further to this, the literature review sets the context for training in dementia and identifies future considerations for the development and delivery of Tier 1 training packages.

Table 1: Keyword search criteria

Key topic	**Subsidiary search terms**			
dementia awareness training	Health, hospitals, care homes, acute	Learning	Application of learning	Impact
Dementia Training, Education	Patients	Professional practice	Reflection	Professional development
Dementia Friends, Communities	Carers, people with dementia			

The following databases were searched via NELSON (Northampton Electronic Library Search Online):

- MEDLINE (NLM)
- Science Citation Index Expanded (Web of Science)
- OneFile (GALE)
- Social Sciences Citation Index (Web of Science)
- SciVerse ScienceDirect (Elsevier)
- Health Reference Centre Academic (Gale)
- Informa Taylor & Francis (CrossRef)
- BMJ Journals
- SpringerLink
- American Psychological Association (APA)
- PMC (PubMed Central)
- Oxford Journals (Oxford University Press)
- Wiley Online Library
- Directory of Open Access Journals (DOAJ)
- BioMed Central
- IngentaConnect
- Life Sciences (JSTOR)
- Grey literature [conference presentations, unpublished work] via a web-based GOOGLE search and Department of Health search.

To ensure the outputs of the search were manageable within the scope of the project searches were targeted to publications completed between 2004 and 2014 (one decade), with a focus on those published from 2009 onwards, in alignment with the National Dementia Strategy.

2.1.6 Policy analysis

A critical discourse analysis of national and local dementia policy was completed to understand the implications of dominant discourses underpinning dementia policy for dementia training. National policies were identified by searching www.gov.uk website encompassing 24 ministerial departments (including the Department of Health) and 331 agencies and public bodies (including Health Education England, Medical Research Council, NHS England and Public Health England). The term ‘dementia’ was searched which resulted in 337 hits; each of which was screened for an explicit focus on dementia and policy. Therefore, ‘correspondence’, ‘independent reports’ and ‘guidance’ documents were removed. In addition, the recognised policies concerning Improving Quality of Life for People with Long-Term Conditions (Department of Health, 2013e) and Improving Care for People at the End of Life (Department of Health, 2013f) were not included in the analysis because they did not have an explicit focus on dementia (See Section 5.2 for list of policies included).

The identified policies were analysed to reveal dominant discourses. The analysis was accomplished using the following steps:

- Each document was read in its entirety to familiarise the researcher with the content of the policy;
- Initial notes were made in the margins to denote relevant ideas and observations which were then used to generate codes. Coding was undertaken at the paragraph-by-paragraph level because this was considered the best compromise between line-by-line coding, where context is often lost (Braun & Clarke, 2006), and section-by-section coding where more nuanced detail may be overlooked;
- Once completed, organising themes were constructed by collating codes;
- We refined the organising themes and named them. A thematic analysis identified 5 organising themes;
- Themes formed the basis of the discourse analysis. This was based largely on Fairclough's (1995, 2009) notion of discourse analysis. The organising themes were analysed in order to identify the dominant discourses which underpinned them. This was done by considering different forms of textual, social and discursive practices. Textual practices involved a close consideration of the uses of language to talk about dementia. Social practices identified the wider power structures and ideologies concerning how dementia is viewed within health and social care and wider society. Discursive practices were defined by the ways in which information in the text is justified or warranted (Jacobs, 2006).

Each partner identified the local policies relevant to their region of Thames Valley. Aspects of the policy specifically related to dementia were charted and a comparative analysis was completed,

2.1.7 Analysis process

Data obtained via individual stakeholder and focus group audio-recorded interviews were transcribed verbatim and analysed thematically. A data analysis matrix was developed for the interview analysis, this was developed to identify key themes in the data and ensure the analysis process was reliable and robust. A sample of the transcribed data was shared across the research team to ensure validity of the process and agreement in the way data had been analysed. Data from the focus groups was analysed through NVivo and key themes identified. The findings of the interviews and focus group are presented in Section 6 and 8, respectively.

Data from the online questionnaire was transferred into the Statistical Package for the Social Sciences (SPSS) for analysis. Descriptive statistical analysis was conducted to identify key trends in the data and open ended questions were analysed thematically. These are presented in Section 7.

Data from the scoping review was entered into a matrix, to identify the key learning outcomes of the training and which were then mapped against the Dementia Competency Framework as developed by South West Dementia Partnership and the Tier 1 Dementia Awareness Competencies as created by London Dementia Strategic Clinical Network. The data was entered into SPSS for analysis of the emergent themes.

2.1.8 Ethical issues

The project was approved by the University of Northampton's Research Ethics Committee and this approval recorded by each HEI's Research Ethics Committee to ensure best practice ethical guidelines were adhered to. Governance approval was also sought from participating NHS Trusts, through the Research and Development teams. The HEI partner's participation in supporting this project was underpinned by the following:

- Participants (staff and stakeholders) took part in the project of their own free will after being fully informed of where and how the information would be used;
- Assurance of confidentiality at all times during the collection of data;
- All analysis done by the HEI partners would use anonymised data and the guarantee that participants would not be identifiable in resultant reports;
- Participants were fully informed of the ways in which the data collected would be used by the commissioners of the project and their partners;
- All research active staff in the HEIs are trained to follow strict codes of practice and are screened by the Disclosure and Barring Service;
- All data collected as part of the project was stored and transferred securely. Storage of data would follow the guidelines set by the Data Protection Act and the Freedom of Information Act;
- The commissioner supported each HEI partner to ensure that the appropriate governance was obtained (where applicable) for the study.

4 Literature review: Current thinking on dementia training

This section reports on the current thinking in peer reviewed academic and grey literature on training in dementia awareness and care, particularly focused on training within the health sector.

4.1 Setting the context

Dementia is a global health priority, with an estimated 46.8 million people with a diagnosis of dementia worldwide (2015 figures), and a predicted rise to 131.5 million by 2050 (Prince et al, 2015). In the UK there are approximately 850,000 people who have received a diagnosis of dementia (Alzheimer's Society, 2013a). Andrews (2014) also reports that in acute hospitals approximately half of patients will have a form of dementia and that 90% of residents in care homes may have dementia, while slightly more conservative, yet still high, figures from the Alzheimer's Society (2014) estimate that a quarter of beds in hospitals and 70% of people in care homes have a form of dementia.

Matthews et al.'s (2013) recent study suggests that the estimates of prevalence rates of dementia may be lower than suggested, despite this caution over the figures, dementia remains a growing global issue and according to the WHO (2012) is one which requires specialist care and support.

A need for greater training on dementia has been recognised at an international, national and regional level (WHO, 2012, NICE, 2006, Department of Health [DH], 2009; DH, 2015) to not only improve professional knowledge and service provision, but also to raise awareness, reduce stigma, reduce isolation and create more dementia friendly communities, better able to care for people with dementia and their carers and enable them to 'live well' with dementia (Alzheimer's Society, 2013b; DH, 2013). The Word Alzheimer's Report (Prince et al, 2015) calls for 'workforce strategies including training' (p.79). One of the ways in which this service provision can be attained is through training and up skilling of the health and social care workforce, as well as within community settings and this has been recognised in international and national policy (WHO, 2012; NICE, 2006; Moyle et al., 2008; DH, 2009). NICE (2006, p.11) discuss the need for better 'access' to skills development training in dementia and that this should be made available to staff working with older people, while the WHO (2012, p.4) identify 'an urgent need to improve the awareness and understanding of dementia'.

This recognition of the need for training is not limited to policy level; a recent DH (2013) report stated that less than a third of GPs felt they had a good knowledge of dementia. Moreover, it was found in the Future Dementia Care in Ireland report (Cahill et al., 2012) that a lack of training amongst GPs, alongside lack of confidence and understanding of the signs and symptoms of dementia, led to their lack of engagement with diagnosis of the disease. The need to develop skills and knowledge in dementia is not limited to primary care, with a need for improved training in acute care and care homes also being recognised. Numbers of trained staff in care homes was found to be low by a report from the An All-Party Parliamentary Group on Dementia (2009), which found that a third of specialist dementia care homes did not provide training on dementia for their staff. This was even less for non-specialist care homes. Research in hospitals has focused in recent years on the care and dignity older patients receive, particularly in relation to being fed and hydrated (Equality and Human Rights Commission, 2011; Chater and Hughes, 2013), where a lack of training is highlighted and the need for good communication skills recognised, particularly in being able to aid staff in minimising potentially aggressive or difficult behaviour (Chater and Hughes, 2013). Over three quarters (77%) of carers responding to a survey by the Alzheimer's Society (2009) reported that they were not satisfied with the care of people with dementia in hospitals, with lack of person centred care, poor understanding of dementia, problems feeding, problems with communication and with dignity and respect at the forefront of this dissatisfaction.

A recent Care Quality Commission report (2014) found that the level of service for people with dementia in care homes and hospitals varies across the UK. The report states that 'good dementia care puts the person at the centre of their care and considers how their dementia affects them. This approach was shown to have a significant and positive impact on the wellbeing and quality of life for people with dementia and their families' (p5). The report continues to state that the provision of poor care can lead to stress and leave people in a vulnerable condition. In order to achieve a high standard of care, the report places training as vital, alongside proper supervision and good access to resources.

The National Dementia Strategy (DH, 2009) set out its aims for dementia, part of which was to improve awareness of dementia, improve the care of people with dementia and to improve diagnosis of dementia. One of the key ways in which these strategic aims can be achieved is through training. Later documentation from the DH stresses the need to embed 'tailored high quality dementia training and development across health and social care' (DH, 2013, p9). While an Alzheimer's Society report (2014) on current opportunities within dementia stresses that the need for 'compulsory, quality-assured training for all front-line health and care staff will raise the bar for dementia care' (p.14).

Health Education England is responding to a call from the Prime Minister David Cameron's Challenge on Dementia to deliver dementia awareness training (Tier 1) to 100,000 nurses and health care assistants by 2015 (DH, 2013). This target was changed and risen to include a further 250,000 staff by March 2015 (DH, 2014) and further changed in line with the Prime Minister, David Cameron's, Challenge 2020 to ensure that all NHS staff are trained 'on dementia appropriate to their role' (DH, p.37, 2015b). In 2015 nearly 440,000 NHS staff had received training in Tier 1 dementia awareness and this will continue to be provided for all NHS staff. This will then lead to Tiers 2 and 3 which will provide more in-depth information for those who work more closely with people with dementia. Further changes to the delivery of dementia training has occurred for all undergraduate health professional courses, which, as of September 2015, now include dementia awareness training (DH, 2015). The way training is being transferred into practice is also being considered by the Corse Knowledge and Skills Framework. Dementia training is also being delivered as part of healthcare assistant and social care support worker training. The aim for training is to ensure:

> '… a motivated and inspired workforce supported by a clear career pathway and evidence based training programmes. We want to see staff providing advice on reducing the risk of dementia and, where people already have dementia, providing high-quality care and support and being able to signpost interested individuals to participate in research. We want to see greater provision of culturally competent care, with staff better able to meet the diverse needs of people with dementia and their carers, supported by for example, improved data regarding the prevalence of dementia and patient surveys that provide feedback about people's lived experience with dementia.'

(DH, p.37, 2015).

Following the mandate from the Department of Health the development of training resources has grown in order to meet the required targets. Changes in training content and delivery approach changed during the course of this project as seen through the DH eLearning platform undergoing revisions and the University of Worcester's 'Stand by Me' programme being accessible online. While a number of curriculum guides have been developed in order to shape the way training is delivered.

The Royal College of Nursing (2013) have aligned the six 'Cs' with nursing practice for dementia care (standing for: care, compassion, competence, communication, courage, commitment). This vision was developed in response to the Prime Minister's Challenge on Dementia (2013) and aims to provide greater awareness of issues and care of dementia for 'all fields of dementia'. In 2011 Skills for Health identified eight core principles for those working with people with dementia in the health and social care field in order to raise understanding of the disease.

The eight principles are:

- Know the early signs of dementia;
- Early diagnosis of dementia helps people receive information, support and treatment at the earliest possible stage;
- Communicate sensitively to support meaningful interaction;
- Promote independence and encourage activity;
- Recognise the signs of distress resulting from confusion and respond by diffusing a person's anxiety and supporting their understanding of the events they experience;
- Family members and other carers are valued, respected and supported just like those they care for and are helped to gain access to dementia care advice;
- Managers need to take responsibility to ensure members of their team are trained and well supported to meet the needs of people with dementia;
- Work as part of a multi-agency team to support the person with dementia (p6).

These principles were set up to support organisations in the development of policies in dementia, but also to develop training and learning outcomes and are used within the Skills for Health Quality Mark assessment.

Further to this a recent curriculum document developed by Dementia UK (2014), sets out a framework for dementia training and provides a guide to the skills and knowledge which should be developed in the health and social care workforce around dementia care. While the curriculum guide has been developed for undergraduate, pre-registration nursing and health and social care education, there is some learning to be had from this document.

The core learning topics identified are:

- 'Prevention and keeping well;
- Identification of dementia;
- Understanding the experience of and communicating with people with dementia;
- Creating effective partnerships with carers & families;
- Equality, diversity and inclusion in dementia care;
- Developing person centred care, assessment and care planning;
- Understanding legal and ethical aspects of working with people with dementia;
- Holistic health and supporting the daily life of people with dementia;
- End of life palliative care;

- Key professional abilities and collaborative working' (p6).

Two further key documents were also being used by Health Education England and the Local Education and Training Boards, tasked with monitoring the delivery of dementia awareness training. These are discussed in more detail in Section 7 but form the basis of the competencies and skills required to reach the Tier 1 dementia awareness target set by the DH's mandate. Since the inception of this project the Dementia Core Skills Education and Training Framework (SfH, EE & SfC, 2015) has been published, which formally identifies dementia training across three tiers and states the learning outcomes at each of these tiers. The tiers are defined as:

- Tier 1 – dementia awareness for all health and care staff
- Tier 2 – knowledge and skills for those who have regular contact with a person living with dementia
- Tier 3 – enhanced knowledge and skills for experts working with people living with dementia

More specifically, Tier 1 is defined as:

> 'Raising dementia awareness, in terms of knowledge, skills and attitudes for all those working in health and care settings'
>
> (Skills for Health, p.11, 2015).

These learning competencies also sit alongside the Quality and Credits Framework (QCF) for dementia, which was established in 2010, following the 2009 National Dementia Strategy. These identify a number of core skills and knowledge criteria courses must incorporate in order to achieve a required level of training, i.e. Award, Certificate or Diploma. These also relate to the length of time a student has studied and the type of training delivered. Currently QCFs are aimed at Level 2 and Level 3 training. In addition, the launch of the Health Quality Mark by Skills for Health (2014) is a way of assuring the quality and delivery of training, with a particular focus on ethics and values, health sector awareness, learning excellence and effectiveness of quality assurance.

4.2 Literature review: Training examples of best practice

Through the development of this project, a substantial number of training courses and resources have been identified, which are available for healthcare staff and the community. There are a range of nationally available training materials as well as local projects which aim to support specific communities. Presented here are a small selection of examples of projects which represent good practice in delivering dementia training to healthcare staff. These examples were identified because they are showing positive results in terms of numbers of staff trained, are addressing a range of subject areas, train a range of different staff roles or have shown a positive impact on practice. One such project was run in Cornwall for acute trusts (a pilot scheme was also run at GP practices and care homes) which aimed to train between 80-90% of staff, focusing on ward by ward teams. Training was run for two hours in-house and was open to allied health professionals as well as ward staff, including porters. The training, based on current policy directives, focused on providing an overview of dementia, communication, national guidance, medication management, pain assistance, palliative care, life story work and the Mental Capacity Act (Wesson and Champan, 2010). The key improvements which were reported following this training were in the taking of life histories of patients and involving family members and carers, furthermore there was a marked reduction in the use of sedatives and greater communication with family/carers. Wesson and Champan (2010) conclude that the training helped to improve awareness and care of those with dementia.

Training developed through the University of Stirling to train the trainer offers a flexible way to deliver training within acute and primary care. The course offers a two day training course for Health Care Assistants to learn to deliver training to colleagues. The training is practice based, with learning developed from clinical experiences alongside evidence based research (Mashta, 2010). The delivery of the training has been set up to allow for busy work schedules and is run in two hour, fortnightly sessions over six months. One of the key benefits of this course has been the ‘insider knowledge’ of having the training delivered by staff from within the organisation, who have an understanding of the working environment. Andrews (2014) report on the way this training promotes a culture change and is a ‘low cost’ way to deliver training to staff.

This course includes a self-study element and focuses on dealing with everyday situations, such as supporting a person with dementia to have a bed bath, as well as problem solving, empathy and environmental support. Practical changes have been reported following this training, for example a meal menu is being changed to include pictures and a colour coded system is being implemented to identify those patients who may not be able to ask for a drink when thirsty (Mashta, 2010).

The University of Worcester, working with the Alzheimer’s Society redeveloped the Focused Intervention Training and Support (FITS) programme for delivery in care homes. The focus of the training was on the use of antipsychotic medication in care homes, managing behaviour and helping staff to provide appropriate support in delivering person centred care. An evaluation of this training found a reduction in the use of antipsychotics and improvements in the care of people with dementia, for example through supported eating, sleeping and mobility. Staff also showed improvements in their knowledge of dementia and their attitudes towards dementia. (Brooker et al., 2014).

Another example of the training which is being undertaken is a project by the National Council for Palliative care, who have developed a training DVD for GPs. The ‘Time to Talk, Doc?’ DVD helps to raise awareness about the end of life for people with dementia (this review was conducted in 2014).

4.3 Gaps and barriers identified in the literature

Despite the range of training which is now being delivered for health and social care staff, there are still some areas where training is not focusing or is not having an impact into practice. WHO (2012) and NICE (2013) both identify potential areas on which training should focus, for example: early diagnosis and recognition of symptoms; understanding of the different types of dementia; pharmacological treatments; application and principles of person centred care; improved communication skills and understanding ethical issues and principles.
Benbow et al. (2011) identified six key areas in which people with dementia and carers felt that training could be offered to healthcare staff. In their consultation, it was identified that knowledge about dementia, person centred care, communication, relationships, support and engagement in activities were the most important areas where skills and knowledge needed to be developed.

There are also gaps in providing knowledge about particular demographic groups within dementia, for example young people with dementia, sexuality and relationships (Westera et al., 2014), ethnic minority and gay/lesbian cultures (Pulsford et al., 2006).

In addition to these gaps, barriers in accessing training and enabling staff to have time off work has also been identified through recent literature (Ward and Dobson, 2014; Westera et al., 2014; Chater and Hughes, 2013) as impacting on the training staff receive. While the range of staff roles who access training is also a consideration. The NHS Confederation (2010) report identified all staff should have access to training, with ambulance staff, hospital porters and catering staff given as examples.

4.4 Future considerations for training development

A review of dementia awareness training (Lock and Moss, 2015) found there is a large array of training available and that the content and delivery style of this training can vary considerably. Common factors in the training tended towards an understanding of what dementia is, the aspects of the training which showed disparity included learning on person centred care, communication and issues of diversity and equality. Furthermore, the value of the training seen by the organisation and the credibility of the training were factors which could influence the level of engagement with the training.

One of the issues raised by Moriarty et al. (2010) relates to the quality of training being delivered in dementia care. This issue is similarly raised in a Care Quality Commission report (2014) which identified that training is often not monitored and the impact of training is not evaluated. The quality of training and its impact is therefore not at the forefront of the training being delivered. This is starting to change, however, as the idea of introducing a quality mark for dementia training is being initiated (Skills for Health). The Alzheimer's Society (2014) also advocate the use of a quality mark to encourage the consistency across different partners and that the quality of training is upheld.

One factor which training should also consider is the links from learning to practice. Raymond et al. (2013) state that 'learning should be about enhancing performance, emphasising both the resolution of clinical concerns and better outcomes for patients' and suggested that the greater learning is related to practice, the more relatable the content. The Care Quality Commission report (2014) supports this finding and recommends that training with a strong practical element and staff reflection is the most effective method. In their research into dementia training in acute hospital settings, Chater and Hughes (2013) found that peer to peer learning and support was beneficial to the learning process and indicated that there be 'a development of a staff-led, ward-based reflection programme, which would provide teams with the opportunity to share experiences and knowledge and offer pastoral support' (p590). In their study exploring the transfer of knowledge to practice in dementia training O'Sullivan et al. (2015) identified that evidence based training and a mixed cohort of managers and care staff fostered practical learning and sharing of knowledge. However, they identified barriers in the transfer of knowledge to practice through the interpretation of legislation and that person centred care is difficult to achieve if the carer has no knowledge of the individual's history or illness, suggesting that the use of 'This is Me' or similar forms can be useful in supporting the transfer of training into practice.

The way in which training is delivered should also be a consideration for future training. In the examples reported above, the use of short study periods was suitable for the acute setting. Ward and Dobson (2014) reported that follow-up sessions to training could be useful for staff to embed learning into practice, share concerns and best practice. Their study also reported that preference to length of course delivery varied according to the organisation, a one-size fits all approach is not appropriate. Similarly, the delivery method also varied, with most of the Trusts taking part in this study favouring face-to-face training when it came to dementia, but some also approving of a mixed approach, for example face-to-face and online.

There is also a need for organisations to collaborate to ensure there is a 'culture change … to improve care and support for people with dementia, their carers and families' (DH, 2013, p9). As the All Party Parliamentary Group on Dementia (2009) reported, training alone is not sufficient to the care of people with dementia, further considerations are also required to ensure there is a change to the way organisations and services think and respond to the needs of people with dementia. This is supported by findings from Chater and Hughes (2013) who recommend partnerships between charitable organisations and acute trusts, in order to develop and enhance dementia care within the acute setting. Another way in which this cultural change could be supported is through the development of interdisciplinary training. Ward and Dobson (2014) identified that such an approach could aid learning, and participants in their study ‘reported an enriched learning environment fostering better understanding between disciplines’ (p39). This collaborative approach is also reported by the WHO (2012) as a positive way to address dementia care. Similarly, Age Concern (2007) suggests this is a way to bring together the physical and mental fields, to provide a more rounded and coherent care for the elderly. Waugh et al. (2011) identified that positive changes to care could result from an inter-professional approach to dementia care training. Their study revealed that staff were able to share a common language and had improved attitudes towards people with dementia.

While there are growing numbers of staff within the health and social sector receiving training, there are still gaps and barriers to accessing training and in particular a sense that training is not always reflected in practice. This is perhaps an area which needs to be developed further and better monitored by organisations. Finally, what is also clear from the research is that at the core of any training should be the individual, as Hughes (2011) writes ‘seeing people as individuals, seeking to understand their needs, however challenging, and doing everything to enable people to exercise control and choice over their care is central to providing high quality care and better outcomes for people living with dementia’ (p410).

5 Policy analysis

5.1 Introduction to dementia policy

In 2007, the Government announced a programme to create the first National Dementia Strategy for England which involved widespread consultation with individuals and organisations. In 2009, ‘Living well with dementia: A National Dementia Strategy’ was published which set out a vision for health and social care transformation across three key areas: improved awareness; earlier diagnosis; and a higher quality of care (DH, 2009). Training and on-going workforce development was cited as being central to achieving the ambitions of the National Dementia Strategy and in 2011, the ‘Common core principles for supporting people with dementia’ was published (DH, 2011c). The guide identified eight common core principles to enable any member of staff working in health or social care to support people with dementia at any stage of dementia and provides a guide to embed the principles in workplaces. By 2012, while some progress was identified in response to the National Dementia Strategy; it was recognised in the ‘Prime Minister’s Challenge on Dementia’ that ‘we need to push further and faster to improve radically the quality of life for people with dementia, their families and carers by 2015’ (DH, 2012a). The Prime Minister’s Challenge outlined a set of considerations aimed at bolstering and accelerating the response to dementia. Three key areas were focused on: driving improvements in health and care; creating dementia friendly communities that understand how to help; and better research.

In 2013, a collection of dementia policies were published; which may have been influenced by the Health and Social Care Act 2012 which came into effect in April 2013. In May 2013, the first annual report on the Prime Minister’s Challenge was published which outlined progress against the original foci (DH, 2013c). The report emphasised the importance of greater collaboration within the new health and social care sector; noting the significance of health and wellbeing boards situated at a local level in driving change. In August 2013, the Alzheimer’s Society published ‘Building Dementia-Friendly Communities’ which provided guidance on 10 key topics for areas which desired to become dementia-friendly. It reviewed up-to-date evidence and provided summaries from projects which were having an impact on people with dementia and their families/carers. In November 2013, ‘Dementia: A State of the Nation’ report was published to provide an overview of dementia care in England, with accompanying maps available at http://dementiachallenge.dh.gov.uk/map. The report provides an update on progress against 10 priorities for action to improve dementia care; presenting evidence of progress and then supplying a ‘call to action’. While the report focused on progress in England; it established the English context for a global summit on dementia among G8 countries. In December 2013, the G8 Health Ministers met to define an effective international response to the globally experienced challenge of dementia. The G8 summit on dementia established a geopolitical agreement ‘to take action to reduce the risk to health and to economic development which dementia currently presents’ (DH and Prime Minister’s Office, 2013:6).

Overall, the collective body of dementia policy sought to improve the lives of people with dementia through increased societal awareness of dementia and radical changes to the health and social care sectors. Within this change, it is important to reflect on dominant discourses underpinning the formation and content of policy as well as the implications of such discourses. This report provides a critical discourse analysis of dementia policies implemented since the launch of the National Dementia Strategy in 2009. In so doing, implications for training and workforce development are identified in terms what it means to lives with dementia in the UK.

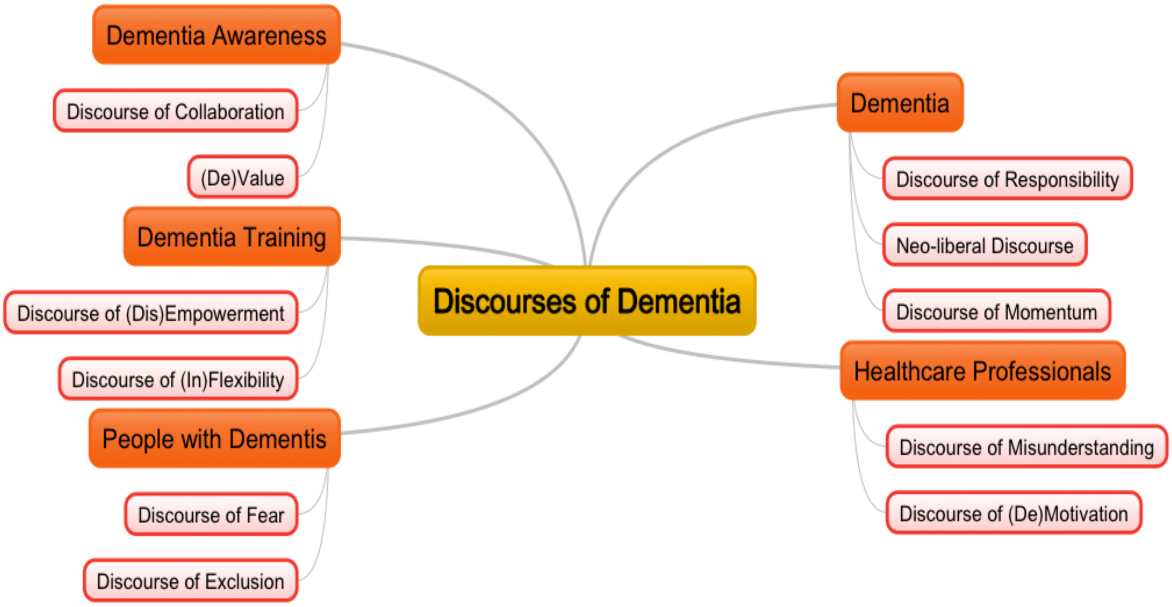
5.2 Discourses underpinning National Dementia Policy

This section presents analysis of key national policies since the publication of the National Dementia Strategy (DH, 2009). 13 policies formed the data corpus for the analysis. These were:

- Department of Health (2009) Living Well with Dementia: A National Dementia Strategy;
- Department of Health (2010) Quality Outcomes for People with Dementia: Building on the Work of the National Dementia Strategy;
- Department of Health (2011a) The Ministerial Advisory Group on Dementia Research – Headline Report;
- Department of Health (2011b) National Dementia Strategy – Equalities Action Plan;
- Department of Health (2011c) Common Core Principles for Supporting People with Dementia: A Guide to Training the Social Care and Health Workforce;
- Department of Health (2012a) Prime Minister’s Challenge on Dementia – Delivering Major Improvements in Dementia Care and Research by 2015;
- Department of Health (2012b) General Medical Services – Contractual Changes 2013/14;
- Department of Health (2013a) Making a difference in Dementia: Nursing Vision and Strategy;
- Department of Health (2013b) Improving Care for People with Dementia;
- Department of Health (2013c) The Prime Minister’s Challenge on Dementia – Delivering Major Improvements in Dementia Care and Research by 2015: Annual Report of Progress;
- Alzheimer’s Society (2013) Building Dementia-Friendly Communities: A priority for Everyone;
- Department of Health (2013d) Dementia: A State of the Nation Report on Dementia Care and support in England;
- Department of Health and Prime Minister’s Office (2013) G8 Dementia Summit Declaration.

A thematic analysis identified five organising themes. Each theme was subject to a critical discourse analysis exploring textual, social and discursive practices to highlight the dominant discourses. While each discourse is overviewed in isolation below, each discourse should be understood as interacting. Figure 2 is a graphical illustration of the dominant discourses.

Figure 2: Dominant Discourses within five Organising Themes



The following sections provide a brief overview of dominant discourses identified within National Dementia Policy. Textual practices are **emboldened** throughout. Social practices are <u>underlined</u> in the quotations. Discursive practices are identified in *italics*.

5.2.1 Discourses of dementia

There were three dominant discourses of dementia within the policies: a discourse of responsibility, a neo-liberal discourse and a discourse of momentum.

5.2.1.1 Discourse of responsibility

Dementia was represented as a growing societal issue underpinned by a discourse of responsibility which was explicit in many of the identified policies. While dementia was represented as a central priority of health and social care, the importance of tackling dementia as a society was outlined as necessary to make a real difference to the lives of people with dementia, their carers and families. Specific disciplines within health and social care were cited as pivotal to achieving a cultural change across UK society, namely GPs in relation to improving the diagnosis of dementia and nurses in providing high quality and sensitive care. The discourse of responsibility emphasised the roles of Local Authorities and Clinical Commissioning Groups in the implementation of the National Dementia Strategy whereas the Department of Health was suggested to support implementation by identifying and sharing good practice (i.e. where local audits had been completed and outcomes for people with dementia had been identified/evidenced).

'…those who can take **responsibility for dementia-friendly communities** in England, Wales and Northern Ireland at local and national levels. For example, national administrations, local authorities and councils, community leaders, clinical commissioning groups, health and wellbeing boards and the voluntary sector.' (Alzheimer's Society, 2013:1)

5.2.1.2 A neo-liberal discourse

Analysis of the policies identified a ‘neo-liberal’ discourse which influenced the narrative and formulation of policy in two key ways. Neoliberalism relates to ‘economic liberalism’ prominent in the 1970s and 1980s which promoted free trade and reductions in governmental spending while increasing privatisation. In this context, health and social care services have fragmented through an implementation of a marketised system in a drive towards a target driven rather than quality driven culture. The neo-liberal discourse frames dementia as a financial burden and threat to the sustainability of the UK and global economy. Power to effect change was again situated at a local level. Some power is vested with people with dementia and their carers to exercise choice and control over their lives, though this is diluted by the support suggested as necessary to exercise such power.

‘Raising the quality of care for people with dementia and their carers is a major priority under the *new Coalition Government*. It is necessary to respond to the challenge in the context of a **changed political and economic landscape**, where the <u>Department’s role is more enabling</u> and less directive.’ (Department of Health, 2010:8)

5.2.1.3 A discourse of momentum

A discourse of momentum underpinned dementia policies. Many of the policies were concerned with progress towards realising the vision of the National Dementia Strategy and this was related to a recognised need to effect socio-cultural changes in which the wider population becomes more aware of dementia and more sympathetic to people with dementia. The discourse of momentum locates dementia as the current driving force for societal change a more inclusive society and action towards improving dementia care is seen as symbolic of the UK’s societal values. Here, the power to drive this agenda forwards is firmly located within health and social care at a local level, as well as the research community and society as a whole. The vision for health and social care services outlined in the policy documents promoted a future society where a person with dementia would be valued and fully included in community life rather than the current situation in which they are silenced and marginalised. In this sense, how society responds to this challenge will come to define our societal standing on such values.

‘One thing is clear: the *Prime Minister’s Challenge on dementia* has created **a new momentum** in health and social care, research and across society as a whole **to do more** to help and support people with dementia, their carers and families.’ (Department of Health, 2013c:4)

5.2.2 Discourses of people with dementia

The policy documents were analysed to identify discourses associated with people with dementia in order to see how people with dementia are framed within current policy. This resulted in the identification of a discourse of exclusion and a discourse of fear.

5.2.2.1 Discourse of exclusion

The discourse of exclusion focused on the ways in which healthcare systems and the public excluded people with dementia from broader society into terms of meaningful social and cultural participation. Such exclusion contributes to the marginalisation and stigmatisation of people with dementia and their families since they are rarely seen in and around the community. However, fear of being excluded can contribute to a reluctance to seek help to avoid gaining or being labelled with a socially stigmatising disease. People with dementia were suggested to be fully involved in all stages of the commissioning process, however, the current situation places people with dementia in a consultative rather than leading role. In effect, GPs and other clinicians were given ‘primary responsibility’ for commissioning. The discourse of exclusion is interesting in that overt messages of ‘inclusion’ concerning listening to the voices of people with dementia were given, but these were invalidated with more powerful and direct messages of exclusion where commissioning decision-making was concerned.

‘**The stigma** of dementia creates a background where both the public and non-specialist professionals find it **hard to talk** about dementia, and seek **to avoid** addressing the possibility of an individual being affected.’ (Department of Health, 2009:25)

5.2.2.2 Discourse of fear

The discourse of fear was identified in the analysis which positioned fear as a driving emotional experience behind help seeking as well as many aspects of living with dementia. Within the National Dementia Strategy, strong emphasis was placed on early detection and early diagnosis – which was seen as contributing to the ‘value-for-money’ agenda, however, the discourse of fear was given in explanation of ‘inactivity in seeking and offering help’ (DH, 2009:26). In essence, some individuals and families fear being diagnosed with dementia and so delay diagnostic help seeking behaviours to avoid stigmatisation in wider society. The assumption is that information/education in itself can transform feelings of fear to those of acceptance. This, however, is likely to be insufficient to alter societal fears about dementia and what is required alongside information/education are more proactive strategies such as positive role modelling of dementia; widespread provision of specialist services (e.g. memory clinics, dementia cafes, support groups); and apposite health and social care staff practises.

‘Imagine feeling **confused and afraid** because close friends and relatives seem like **strangers**; being unable to leave the house **alone** because you might not be able to find your way back; or seeing **the fear** in your loved one’s face, as they **struggle to make sense** of familiar surroundings.’ (Department of Health, 2013c:3)

5.2.3 Discourses of healthcare professionals

Two dominant discourses were identified that underpinned the way healthcare professionals understand and provided care: a discourse of misunderstanding and a discourse of motivation.

5.2.3.1 Discourse of misunderstanding

Healthcare professionals within dementia policies were seen as lacking knowledge about dementia, contributing to a discourse of misunderstanding. These misunderstandings of dementia derive from a medical perspective and include:

1. That nothing can be done for people with dementia;
2. Dementia is a normal part of the ageing process;
3. People with dementia lack the capability to make informed choices and decisions about their care and
4. That people with dementia require medication to contain behavioural disturbances.

It is argued here that the misunderstandings held by healthcare professionals’ tend to support the biomedical lens applied to dementia which normalises dementia as a natural part of ageing and so presents dementia as an intractable condition for which little can be done. The medical lens on dementia highlights cognitive decline and the accompanying reluctance to act, as well as bringing into question the capacity of people with dementia to express their feelings and thoughts and make informed decisions. This situates people with dementia in dependent relationships with health and social care professionals, who then have the power to make choices and decisions on their behalf. Health and social care workforce training to improve specialist knowledge was articulated as fundamental in achieving the ambitions of the dementia policies.

‘A *review of the evidence* confirms that there is a marked reluctance on the part of primary care to be directly involved in the diagnosis of dementia for reasons that include: the belief that **nothing can be done for dementia**; concerns about competency; and concerns for the availability of resources.’ (Department of Health, 2009:36)

5.2.3.2 Discourse of (de)motivation

This discourse focused on the health and social care staff attitudes towards working practices to enable people to live well with dementia and, combined with the localism agenda, drivers of change were located within local governmental structures with healthcare professionals who have local knowledge combined with necessary skills. A key challenge cited in the National Dementia Strategy (DH, 2009) referred to the unwillingness of some healthcare professionals to adapt their practice to provide care for people with dementia. In this way, the discourse of (de)motivation illustrates the ways in which cultural transformation is suppressed and how messages of change can often rest at the level of rhetoric. Policy changes to UK healthcare systems and structures have placed responsibility for enacting change with Local Authorities and Clinical Commissioning Groups to improve quality of care and quality of life for people with dementia, but measurable change in practice were, in many cases, limited.

‘**Financial rewards** for hospitals offering quality dementia care. From April 2012, **£54m will be available** through the Dementia CQUIN payment framework to hospitals offering dementia risk assessments to all over-75s admitted to their care. From April 2013, this will be extended to the quality of dementia care delivered.’ (Department of Health, 2012a:20)

5.2.4 Discourses of dementia training

There were two dominant discourses underpinning dementia training in the policy documents: a discourse of (in)flexibility and a discourse of (dis)empowerment.

5.2.4.1 Discourse of (in)flexibility

The policy documents all referred to the shifting demographic profile in the UK in terms of projected increases in the ageing population and, therefore, of the numbers of people with dementia. Dementia is understood as affecting people of different genders, ages and ethnicities. In addition, the various types and stages of dementia were mentioned in policy. The identified variability of people and disease emphasised the need for training to be flexible to allow its adaptability to different populations. Training was aimed at diverse audiences including the public and professional stakeholders. A further challenge identified in policy was that health and social care was delivered in a range of settings (e.g. hospitals, care homes, private residence etc.). This requires that policy directives were flexibly applied in different local contexts. The discourse of (in)flexibility set the scene for less prescriptive approaches; rather policies sought to embed a set of common principles against which training programmes could be mapped. High value was placed upon an ‘equalities’ agenda within the discourse of (in)flexibility, especially in relation to the sensitivity of training packages. While the flexibility of training was highlighted regarding issues of diversity and equality, the diverse forms of dementia were rarely articulated in relation to the needs of disadvantaged groups in relation to training or core principles.

> ‘The commissioning pack makes it clear that specific attention should be given to **disadvantaged groups** to ensure **equality** of access and that services are **sensitive and appropriate to particular needs**. In relation to dementia, groups who require particular attention include: **people with learning disabilities; people with early onset dementia; people from BME communities; carers**.’ (Department of Health, 2011b:13)

5.2.4.2 Discourse of (dis)empowerment

Dementia training was also constructed through an overt discourse of (dis)empowerment. By empowerment, we refer to the ability of people with dementia to reflect upon, as the first step of resistance, discourses that position them as subordinate subjects. Certainly, the empowerment of people with dementia and their carers was located as a primary aim of the National Dementia Strategy. In this sense, empowerment was articulated in terms of control of care through facilitation of people with dementia ‘doing’ things themselves and making their own choices. What is interesting here is the direct challenge to risk-aversive strategies and practices seen elsewhere in the delivery of patient care which often stifles personal control and choice. In the current context, risk-taking is supported. Dementia training was expected to facilitate the choices of people with dementia in decisions affecting their present situation and future lives. In contradiction to the intended target of empowerment, people with dementia are positioned as subordinate to the DH who will ensure that they get the appropriate treatment and support. However, a more subversive discourse of disempowerment can also be discerned in the policy documents. The discourse of empowerment clearly positions GP’s and nurses at the forefront of enabling choice and control, and the Alzheimer’s Society and the DH as ensuring the empowerment of people with dementia. The notion of disempowerment appears when health and social care professionals (as well as carers and family members) are positioned as unofficial gatekeepers to situations where the choice and control of people with dementia are implicated.

> ‘You (Health and Social Care Workforce[1]) should… **do things together** with the person rather than for them, supporting their **own choices even if you regard this as risky.** Risk-taking is a part of everyday life – a person with dementia is no different.’ (Department of Health, 2011c:10)

5.2.5 Discourses of dementia awareness

Two dominant discourses were revealed in relation to raising levels of societal Dementia Awareness: a discourse of collaboration and a discourse of contribution.

5.2.5.1 Discourse of collaboration

A discourse of collaboration was evident in the policy documents. The discourse promoted collaboration as a key mechanism for making a real difference to people’s lives. The discourse of collaboration exhorted organisations to work in partnership to solve the problems associated with delivering high quality, person centred care to people with dementia; as well as promoting collaboration across organisations throughout UK society. While dementia training was primarily focused on health and social care staff, it was recognised that such training was relevant to

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[1] Our addition in brackets.

community-based non-health and social care organisations for dementia friendly communities to be properly realised. An initial aim of policies was to bring dementia out of the shadows; and then work together collaboratively to enable people with dementia, their carers and families to live well with dementia by upholding principles of inclusion, respect and compassion. Of particular interest here was the creation of a strong link between health and social care responsibility and societal responsibility for early diagnosis. Collaboration here extends beyond the health and social care sectors into the private business sector.

‘Diverse groups and organisations, such as dentists, opticians, pharmacists, local hairdressers, faith groups, social care employers and trades people, can play an important role. Working with *Alzheimer’s Society*, we will identify the key sectors of the community considered important when supporting those with dementia to live well in their communities.’ (Department of Health, 2013c:27-28)

5.2.5.2 Discourse of (de)value

While this positioned people with dementia as members of society who can and do contribute to relationships, families and communities, it also pointed to personal, social and socio-structural difficulties that prevent such contributions. The devaluing of people with dementia in society is clearly signalled in the policy documents where issues of stigma once again appear to undermine their everyday experiences. The policies outlined how people with dementia hold low expectations about their value and contribution to their communities and report a loss of social connections as people due to stigma and fear. While in many ways the policies portrayed people with dementia as being separate from society, an increase in dementia awareness was viewed an approach to integrate people with dementia as valued, purposeful and integrated members of society.

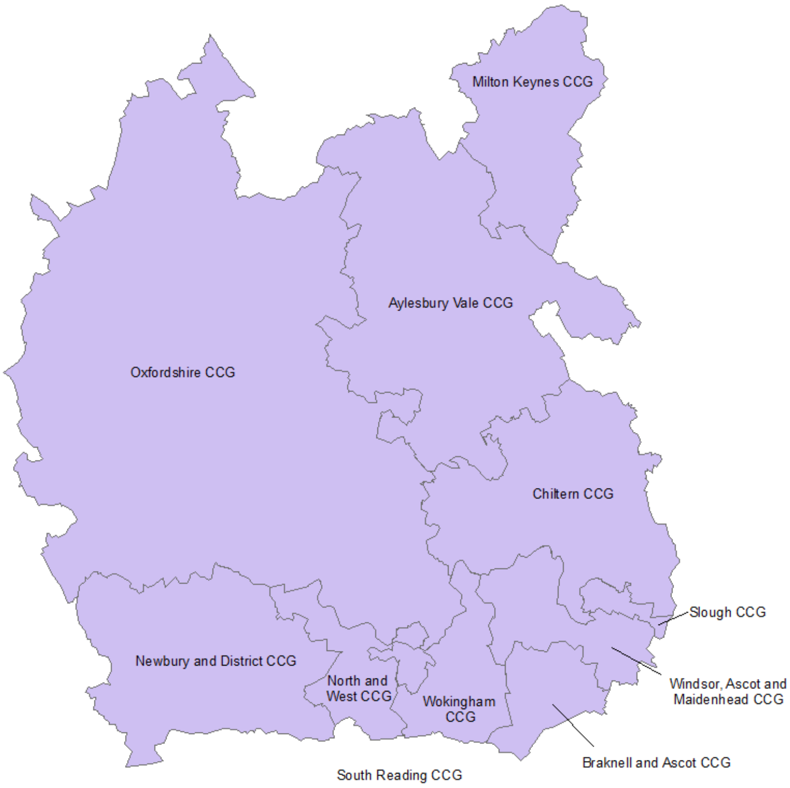
‘People with dementia talk about **stigma** and **social isolation**. They report **losing friends** following their diagnosis, seeing people cross the street to **avoid** them, **feeling lonely**, and struggling to use local services.’ (Department of Health, 2013c:12)

5.3 Understanding dementia policy in the Thames Valley region

The formation of policy is critical in driving practice. This section provides an overview of local Health and Wellbeing Board Strategy and Joint Strategic Needs Assessments in Thames Valley. To provide a context for this study the Local Authority and Clinical Commissioning Group geographic boundaries are shown in Figures 3 and 4 respectively to show the geographic disparities between the boundaries.

Figure 3: Thames Valley – Local Authority Boundaries

Figure 4: Thames Valley Region – Clinical Commissioning Group Boundaries



The Health and Wellbeing Board (HWB) and Joint Strategic Needs Assessment (JSNA) documents were analysed in a comparative framework and the findings are presented in Table 3. Figure 5 illustrates the geographic areas represented in Table 3. The focus of the exercise was on recommended actions. Thus, prevalence data, and overviews of dementia services were excluded. Data that were included were dementia priorities and recommendations for implementation.

Figure 5: Geographic Boundaries for Local Dementia Policy Analysis

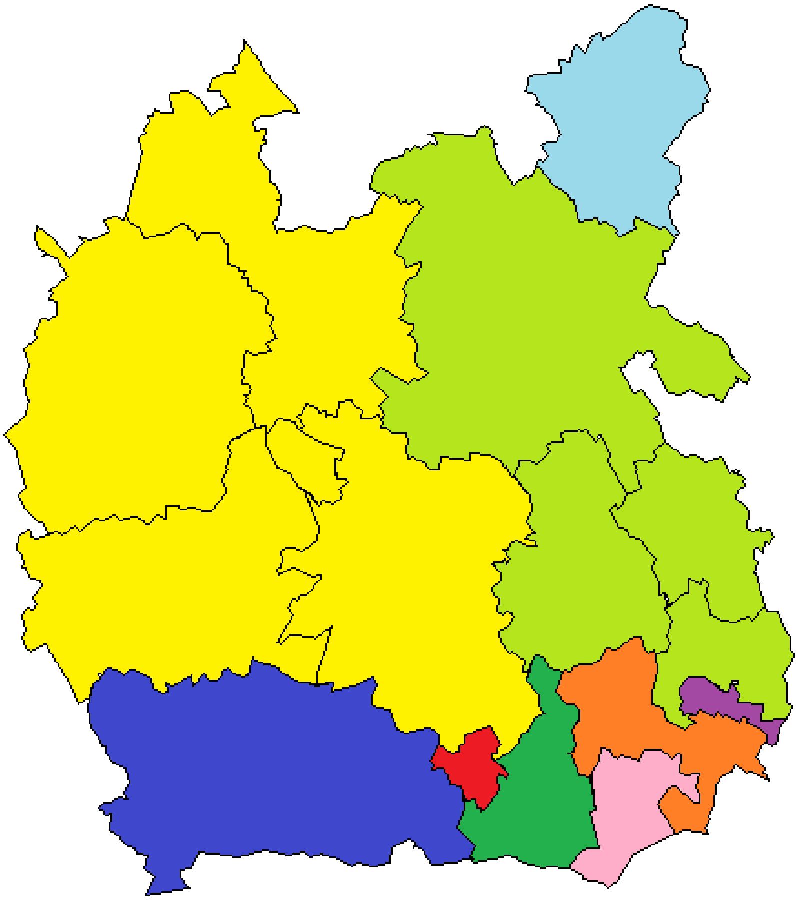


Table 3 illustrates how localities have different dementia improvement and implementation plans. Importantly, not all areas emphasise the importance of improvement to health and social care workforce training and development. This is critical as local policy drivers do not in some areas prioritise dementia training and awareness at the policy, strategy and planning level, thus, potentially impacting upon training provision.

Overall, the exercise is illustrative of the complexities of the setting for this study and provides a context for potential disparities between areas in the provision and quality of dementia training for the health and social care workforce.

Table 2: Local HWB and JSNA Dementia Policy Analysis

Issue	**Oxford-shire**	**Milton Keynes**	**Bucks**	**Windsor and Maiden.**	**Bracknell Forest**	**Wokingham**[2]	**Slough**[3]	**Reading**	**West Berks.**
Improved Diagnosis	x	x	x	x	x		x		x
Earlier Diagnosis	x	x		x	x		x		x
Access to Care	x	x	x	x			x		
Improved Care	x	x		x			x		
Dementia Champions	x			x					
Dementia Friendly Communities	x			x	x		x		
Dementia Awareness	x		x	x	x		x		
Medication	x			x	x		x		
Improved Professional Understanding	x			x	x				
Carer Support	x	x	x	x	x	x			x
Better Community Services	x	x	x	x	x				
Improved Hospital Care	x	x		x	x		x	x	
Improved residential and care home provision	x	x	x	x	x		x	x	
Workforce Training and Development	x	x	x	x				x	
Improved Crisis Services	x		x						
Improved Early Intervention Services	x		x		x				x
End-of-life care support	x		x	x					
Disadvantaged groups	x		x	x	x	x	x		x
Better Information	x			x	x		x		x

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[2] Local policies referred to implementing the National Dementia Strategy but did not provide any specific priorities based on an assessment of dementia in the relevant locality, therefore issues were not selected.

6 Fieldwork with healthcare providers

This section presents the findings from the 32 stakeholder interviews, which were undertaken across the Thames Valley region with Local Authorities, healthcare, social care and charitable organisations. The breakdown of which is:

- Acute Trusts (n=8)
- Local Authority(n=5)
- Care/Residential Home (n=4)
- Charity (n=4)
- General Practice (n=3)
- Ambulance services (n=2)
- Community Mental Health Care Trust (n=2)
- Dental representative (n=1)
- Domiciliary Care provider (n=1)
- Mental Health Care Service (n=1)
- Pharmacy representative (n=1)

From these organisations, a range of different staff roles and levels were interviewed, for example: mental health representatives, porters, practice educators, learning and development representatives, dementia lead representatives and an older people’s service representative. This provided a wide range of views on the issues relating to dementia training of which this section presents the key emerging themes.

6.1 Drivers for undertaking dementia training

6.1.1 People with dementia

There were a number of drivers for undertaking dementia training, primarily though the desire to provide a quality service for the care of people with dementia and their carers was at the forefront of why training was being delivered. Interviewees discussed this in a number of ways, in terms of being able to support clients, in ensuring that people with dementia received the best benefits from the service and of staff being able to signpost and provide advice and guidance to family members.

‘…ensuring that all our staff, whoever they work for, have an understanding of what dementia is, how to support somebody with dementia, the different types of dementia… and how they can work with and support people who have dementia.’ (County Council)

‘… to improve the service that we can deliver to patients…’ (GP)

‘…if we don’t understand dementia, we are then not meeting the needs of our dementia residents.’ (Care Home)

‘If a relative asks you how do I get Power of Attorney you need to know where to look for that information.’ (GP)

Some interviewees spoke of the need to raise awareness within the community about dementia issues and also that people with dementia should be enabled to live at home for as long as possible, as one interviewee stated '…part of our strategy… is to keep people at home for as long as possible. So equipping carers to be able to support people to stay at home' was an important driver.

'There is still a stigma. We need to challenge people's perceptions - it is possible to live well with dementia.' (Charity)

'I think some of the issue is about the general public's awareness of patients with dementia.' (Acute Trust)

6.1.2 Core business

Associated with the need to support people with dementia was that for many people with dementia represented their organisation's core business and therefore ensuring that services were fit for requirements was essential. Part of this was to ensure staff were trained appropriately. A number of interviewees also talked about an aging society and that services needed to ensure they were ready to care for this population. One interview also noted there needed to be a recognition that people with dementia are not necessarily going to be treated in elderly care wards only but may be patients across the whole service.

'… the fact that … two thirds of patients at the [organisation name] are over 65.' (Acute Trust)

'… have a high incidence of patients with cognitive difficulties, so it's just to raise awareness that patents with dementia are everywhere in the Trust, not just in elderly care.' (Acute Trust)

'… most of the people within our [organisation]… will have some form of cognitive impairment so … it has been mandatory.' (Care Home)

'I think it's just the knowledge that the … majority of our service users are living with dementia… and I think that drives us.' (Domiciliary Care)

Care and service provision was discussed in terms of providing best practice and quality of care, not just about meeting the needs of people with dementia but ensuring that the care that was delivered was of a high standard.

There were also a number of reported benefits for the organisation in upskilling staff, not least of which was ensuring customer satisfaction. One interviewee talked about the need for repeat custom and that training was a way to provide a quality service, 'if you're helping the customers and the customers keep coming back to you, it will help… because you're actually helping the business'.

This was also discussed in relation to staff pressures and the way that training could help to raise skills and knowledge and therefore better enable staff to meet the demands of their jobs. One interviewee referred to the way training could help staff to 'do a better job', while another thought that training not only helped staff to carry out an improved service but that this could also have a beneficial impact on people with dementia. In this way training has a multi-faceted role in supporting the person with dementia, the staff member and the organisation.

‘… it benefits the staff if they’ve had training…. it means they can do their job easier and better …. if staff treat people with dementia in the proper way and work with them in the proper way, it makes life a lot easier for them… it’s kind of beneficial for people with dementia.’ (Care Home)

Finally, there was acknowledgment that a skilled workforce was a way of showing that a service was capable of providing a quality product, particularly where services were to be commissioned. This was important for both those organisations who commission services but also for those seeking to be commissioned and needing to meet commissioner expectations and standards.

‘If you want the contract and you want the work, you need to be able to train the staff.’ (Domiciliary Care)

‘… it was a formal bid…, so we’ve obviously go to fulfil those bids.’ (Pharmacy)

‘… we commission a great deal of services… So it’s a key priority for the organisation, in terms of commissioning work.’ (Local Authority)

6.1.3 Government policy

Perhaps unsurprisingly, the need to meet government targets and policy drivers was central to this discussion. Meeting the Prime Minister David Cameron’s Challenge and Health Education England’s targets to train 80% of NHS staff was recognised as a challenge for some but was also a clear driver for the delivery of training. One interview put it quite simply, ‘we’ve been told to do it’.

‘… the National Dementia Strategy meant we did a dementia audit, … I think it was realised that this is where the big push came from about staff training in dementia, to fulfil its objectives.’ (Acute Trust)

‘The other drivers have come nationally through Department of Health through Health Education England.’ (Acute Trust)

‘Government drivers do influence the training which is prioritised within the organisation.’ (Community Health Service)

Alongside national policy, local and organisational policy/strategy had an important influence, for some of those interviewed, as to what training was being delivered.

‘… it keeps HEE TV happy that we’re meeting those regional figures.’ (Acute Trust)

6.1.4 Quality

While quality of care has already been discussed as a driver for implementing training, this was also reported to be important in meeting the Care Quality Commission (CQC) or Quality, Innovation, Productivity and Prevention QIPP requirements. In a similar way to having to meet commissioner standards, those who were interviewed were aware of the need to meet nationally recognised care standards.

‘And kind of CQC expectations.’ (Acute Trust)

‘…but it’s also justifying it to CQC.’ (Ambulance Trust)

‘QIPP training targets have influenced the need to provide dementia awareness training.’ (Community Health Service)

Alongside meeting these quality standards, meeting the requirements of national guidance was also referred to, with one interviewee highlighting the need to consider best practice from guidance documents, such as the Skills for Care Guidance. The legal requirements of maintaining quality were also noted by one interviewee, who stated clearly that meeting the needs of the residents was ‘the law’.

Quality was also discussed in terms of developing a baseline of skills and knowledge for staff, ensuring staff met a required standard of knowledge was important to achieve and one which could then be built upon. Certification and gaining qualifications was also important to the development of this benchmark, with interviewees recognising the importance of quality marks for training and having staff who could count training towards their CPD points.

‘… the other driver is we are trying to link that to the care certificate because actually it is quite clear that we need to just expand the knowledge out there, and actually get a baseline.’ (Mental Health Service)

6.1.5 More training

The need for training was also influential, not only was it reported that staff were making requests for training, but also interviewees noted throughout the interviews that training in higher levels was now required.

One issue regarding the training was the distinction between training clinical and non-clinical staff. For some of those interviewed, the focus of training was for clinical staff:

‘So all of our training that we do, with the exception of the non-clinical, all of the training we do meets Tier 1…’

6.1.6 Funding

The need for funding to deliver training was important for some organisations, while others were delivering free training so as to mitigate this as a barrier for accessing training.

‘… you don’t have any dementia training. You know you can get this for free, please book it.’ (Local Authority)

‘… provide a raft of training free of charge to care organisations… there is very little excuse for saying we haven’t trained our staff.’ (Local Authority)

‘We’re quite active in [county] but that’s because of extra funding.’ (Care Home)

Financial incentives to undertake training were important for some, as one interviewee openly discussed: ‘… it’s also an incentivised area for us to encourage and focus on’.

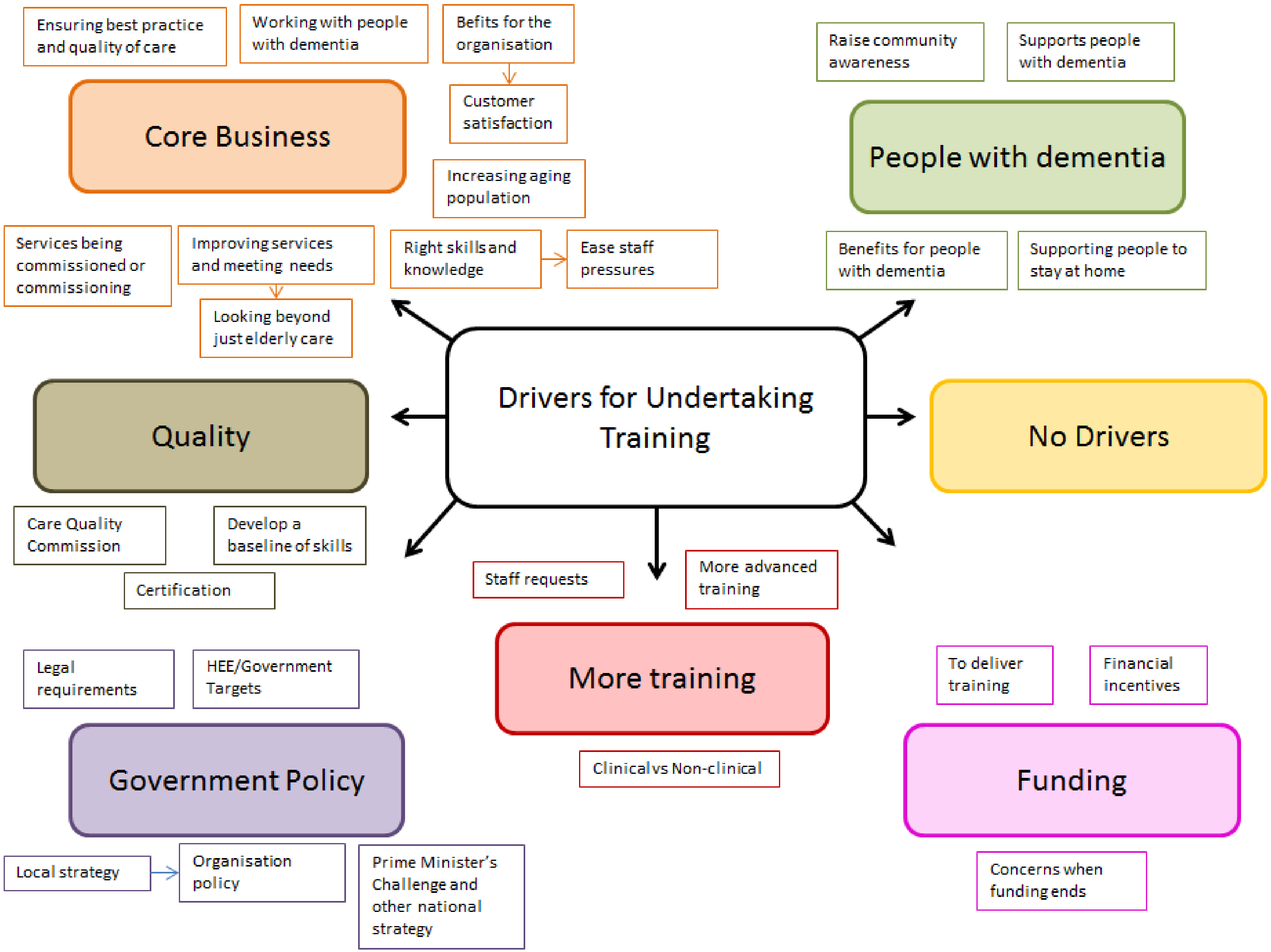
What also came through the interviews was a shared concern that some currently funded training initiatives would be coming to an end and would then leave a gap in provision. The need for the current momentum of training to be maintained came through strongly and that this now needed to be built on with more advanced training.

‘We had a number of initiatives funded under the Prime Minister’s Dementia Challenge, a lot of these have run their course and are winding down now.’ (Local Authority)

6.1.7 No drivers

Only one organisation interviewed in this study did not report to have any particular drivers for the delivery of training, although they did intimate that this was under development.

Figure 6: Drivers for undertaking training theme map



6.2 Staff undertaking training

The discussion during the interviews about who should receive Tier 1 training in dementia awareness was focused on which staff should be trained, but the level of training and requirements for higher than Tier 1 training were also central to these discussions.

6.2.1 Staff

The clinical or non-clinical debate was raised again, with some organisations focusing on training clinical staff. This was not universal, however, as a number of those interviewed were keen to ensure that all staff, at whatever level or role had access to training, if they were likely to meet or care for a person with dementia then they should have training.

‘… and make some dementia training available to all staff in [organisation], who interact with people with dementia.’ (Acute Trust)

‘I do think it’s very important that everybody, from the cook as well.’ (Care Home)

For those who talked about training a range of staff, some of the roles discussed were: doctors, nurses, porter staff, security staff, cleaning staff and reception staff. One of the benefits of training all staff was thought to be that staff absence, through holidays or sickness, could be covered by staff with the same knowledge and skills.

One interviewee was keen that all staff in their GP practice were dementia aware trained, however the reality of delivering training to a large group of staff at one time meant that a priority had to be made for one group of staff, in this case the doctors were identified as the primary group to receive training.

Some interviewees spoke with a great deal of passion and commitment about the need for a range of staff to receive training. The way that this could boost staff morale and job satisfaction was important, as was being recognised as a vital part of the workforce.

‘I’m passionate about trying to get training for porters because I think that the Health Service… are missing out on a workforce, quite a motivated workforce, quite a conscientious workforce… things like national qualifications gives them credibility…’ (Acute Trust)

As part of the debate, there was an acknowledgement that the training was being phased so there was a distinction between staff who were currently being trained and those who would receive training at a later date. However, some of those interviewed also made it clear there were some staff who they did not see as a priority to train, examples were given as porters, reception, finance staff, volunteers and domestic staff.

6.2.2 Existing knowledge

One aspect which was important to gauge was the current level of expertise amongst staff and ensuring that training was offered to staff who needed it. One organisation was able to report that their staff had been employed with strong backgrounds and expertise in dementia and therefore they had not been required to access the Tier 1 training. Another interviewee also reported that they did not want to have to deliver basic training to staff with years of expertise of working in this field.

‘… we’re quite fortunate in the fact that people have already got that strong knowledge base… so we haven’t necessarily had to provide an induction or any basic training, because everybody knows it already.’ (Charity)

There were also some assumptions that certain staff would already have dementia awareness training through their professional qualifications. For example, one interviewee in discussing the needs of GPs thought that they would require a higher level of training as they all had a basic awareness, this individual then noted that this was an assumption and that it was a ‘hope’ that GPs were all at a certain level. Similarly, another interviewee reported that training was not being offered to some staff as there was an assumption that dementia awareness would have been covered by their professional training.

Transferring the knowledge and skills of staff who had trained abroad into the UK experience was core to understanding staff’s existing knowledge, as was assessing those staff who were not newly qualified.

‘We are looking at people that qualified a long time ago…’ (Acute Trust)

6.2.3 Levels of training and the need for higher levels of training

The level of training being offered to staff was often dependent on the level of engagement they had with people with dementia, so those who were caring for a person with dementia on a regular basis were more likely to receive training, particularly at a higher level. The adage that one size fits all was not thought to apply for dementia training, where the level of delivery (as well as the style) should be tailored to the staff attending. A couple of interviewees discussed that the needs of one group were not the same as another and that delivering the same training for clinical and non-clinical staff was difficult:

‘… if you’re going to stimulate GPs, you’ve got to be at one level and if you… want to increase awareness for the receptions staff, that’s another level.’ (GP)

‘… but the assistants… do it in a softer approach for them… If I bombard them with clinical, they would, it would just wash over their head, they would switch off.’ (Pharmacy)

‘… when you’ve got clinical and non-clinical roles, people probably feel like I don’t think I can attend that…’ (Acute Trust)

Another interviewee noted that the content also needed to be reviewed when delivering to different groups, for example for some the more medical approach would be beneficial because of their level of expertise and interests but this may not be suitable for the more front facing staff who would benefit from a more social approach.

Throughout the interviews, the need for higher level training was evident, with interviewees wanting to access Tier 2 and 3 training. The need for higher level training was needed for staff who had greater involvement in the care of people with dementia, as one interviewee reported:

‘Tier 2 training would be more detailed training for people who fairly regularly interact with people with dementia…. Tier 3 training would be more expert training for people who have a great deal of time specialising in dementia care.’

Another interviewee simply stated that ‘all I want is level 2 and 3’.

6.2.4 Mandatory training

For some interviewees the delivery of dementia awareness was mandatory for all new staff. However, this was not the case for everyone. The caution here was the potential cost for making dementia training mandatory and, as will be discussed in the section on barriers to training, the balance of other conflicting priorities was also a concern. One interviewee discussed how dementia training had recently been made mandatory for the care staff within their organisation and that while this was not mandatory for reception and other levels of staff, the workshops were being made open to all staff who wanted to attend.

Another interviewee discussed the benefit of making dementia training mandatory, saying that it would help ‘give some degree of leverage that we don’t always have’.

6.2.5 Training for the community

Some of the interviewees had strong links with their community and were delivering training to community groups, local businesses and also to their volunteers. This community engagement was felt to be important and is discussed in more detail in the section on Dementia Friends Schemes. Care homes and Local Authorities in particular were reported to have a positive engagement with their communities, and have provided training to: supermarkets, carer groups, village communities, schools, church groups, fire services, housing officers and community officers. As well as these organisations delivering training to communities, one care home discussed delivering training to a GP surgery and local pharmacies. One Local Authority also encourages carers and residents to attend the training they deliver in care/nursing homes.

‘… so people who are working in shops or… bus drivers or whatever, to have that sort of awareness is really what we should be aiming for I think.’ (Local Authority)

This level of community engagement was not specific to the care homes and local authorities, as one of the ambulance organisations interviewed stressed the importance of training a wide range of their staff and to share that with the ‘rest of the health economy’ because it may be that staff know people within their communities who have dementia and therefore can raise awareness beyond the confines of their workplace. This organisation were also keen to engage their community in the development of their dementia training, so that they could input into what topics should be delivered.

Figure 7: Who should undertake training theme map

6.3 Training delivery

The interviews covered in some detail the current delivery of dementia awareness training, in terms of what the training covers, the length of time, learning style and level of training. In addition to the Tier 1 training being part of the discussions, training be accessed at higher levels was also prominent.

6.3.1 Content

In terms of the content of the training, most of the organisations talked about what would be expected in a dementia awareness course, for example the signs and symptoms, what is dementia, brain function, person centred care approaches etc. These were topics which are required under the Tier 1 competencies and are standard in this level of training. What was of particular interest was the inclusion of some different topics in some of the training, which offered a wider perspective on dementia and addressed some specific areas, for example:

- Learning disability
- Whole pathway picture
- The 'unpopular patient'/ Challenging behaviour
- Patient experience of dignity
- SPECAL
- Nutrition and diet
- Reminiscence
- Tips and techniques for carers and family members
- Undiagnosed dementia

'We'll look at the whole journey from the patient at home to why they came to hospital to what happened in hospital, how we did things…, how we could have done things... Then to the point where they go home.' (Acute Trust)

The relevance of content to practice was very important, being able to give real life scenarios and enabling attendees to talk about their experiences was thought to be of great benefit to the learning process.

One interviewee had approached the delivery of their workshops in a unique way, drawing upon the best practice of other existing teaching and using these within their own in-house training. For example, working with the Contented Dementia charity, this organisation were using SPECAL training within their dementia awareness training, and so giving their staff access to, what was considered, the best practice available.

6.3.2 Delivery style

A whole range of delivery and learning styles are being used in dementia training. This is the list of training which was discussed.

- Interactive
- Workshops
- Simulation
- Classroom based
- ELearning
- Video
- Mixed approach
- Exercises
- Workbooks
- Signpost booklet
- Scenarios
- Virtual dementia tour
- Quizzes
- Hands on training
- Leaflets

A number of those delivering training referred to training that should be 'fun', 'entertaining', 'stimulating' and 'hands on'. This was thought to encourage learning and a mixed approach also allowed for questions to be asked, discussions had to link the learning to real clients or patients/residents.

The training being offered is often run in modules or short sessions which staff can access at different times. So, for example a session on person centred care may be run at one time and then one on nutrition or what is dementia run at another time. This was a practical way to deliver the training as it could be accessed during lunch breaks, after shifts and means that staff are not out of work for a whole day.

The train the trainer model has also been used quite widely across Thames Valley and has proved to be a valuable approach. This again means that staff can be trained at times which are more suitable to their work patterns, by staff who know the organisation and it is a more cost effective method for many.

One of the organisations interviewed were developing new ways of delivering training, through more of a drip feeding method of delivery via tips of the day messages to staff and information leaflets (for both staff and to pass on to carers/people with dementia), to act as quick reference guides. Overall, there was quite a creative approach to the delivery of training with a focus on engaging staff is the best way possible and in ensuring the training was practical and meaningful.

6.3.2.1 ELearning or face-to-face

One issue which was discussed by nearly all of those who were interviewed was the value of eLearning, with the question raised of whether this is a suitable medium for delivering dementia training?

Some reported to be happy with the eLearning content currently available and felt that it met their needs and provided a recognised comparable standard.

‘So it’s been the online, national content modules because we figured that was a starting point, and it was a standard and it was the same material that the rest of Thames Valley and Wessex were going to be using…’ (Ambulance)

‘We think online has a very important place. It has the advantage of being used or, where you can ensure that the same training is provided to a very large number of people, and it can teach some basics of dementia care.’ (Acute Trust)

However, for many, eLearning was not suitable on its own. There were concerns that it was difficult to test the understanding of dementia and some questioned how relevant it was to practice. In addition, it was recognised that staff could work through the study programmes without taking in the content and would be able to come out with a certificate at the end but not necessarily with the knowledge.

‘it doesn’t give you the skills to be out there.’ (Care Home)

‘All they care about is getting their certificate at the end. There’s lots of tricks with eLearning that you can get your certificate without actually doing the whole programme.’ (Acute Hospital)

ELearning was referred to as something which could be accessed before a training session or as a ‘supplementary’ to the face-to-face delivery.

Also for those who are not computer literate, or did not have access to computers this delivery could be a barrier. However, it was acknowledged that eLearning was a good way to train a range of staff and that this was a format which could be accessed around staff work commitments.

While some preferred the face-to-face approach, others thought a ‘blended’ approach to learning was best, being able to offer eLearning and face-to-face training, for example.

‘I think a blended approach is definitely something that is… essential… I think online learning definitely has its place but there’s no one to ask questions of and therefore the relevancy to practice with those, which usually comes about with those questions, is absent. So I think a blended approach certainly with workshops and the online training is absolutely essential.’ (Care Home)

Whether by face-to-face or a blended approach what was key here was the opportunity for staff to talk to each other, to share experiences and learn from each other.

‘… the opportunity to hear the experiences of other people, and things that they have tried that might work.’ (Local Authority)

6.3.2.2 Training facilitators

The training discussed was delivered by a number of different providers, such as Alzheimer’s Society, Age UK, Local Authority and HEIs. A number of the organisations had developed their own in-house training and were successfully delivering this to their staff.

The use of external speakers as part of the training was also encouraged by a couple of those who were interviewed, as it was recognised that this could offer specialist knowledge and added kudos to the training.

‘… we had a speech and language therapist come in and talk about communication with dementia… so we were very lucky to be able to tap into that resource…’ (Acute Trust)

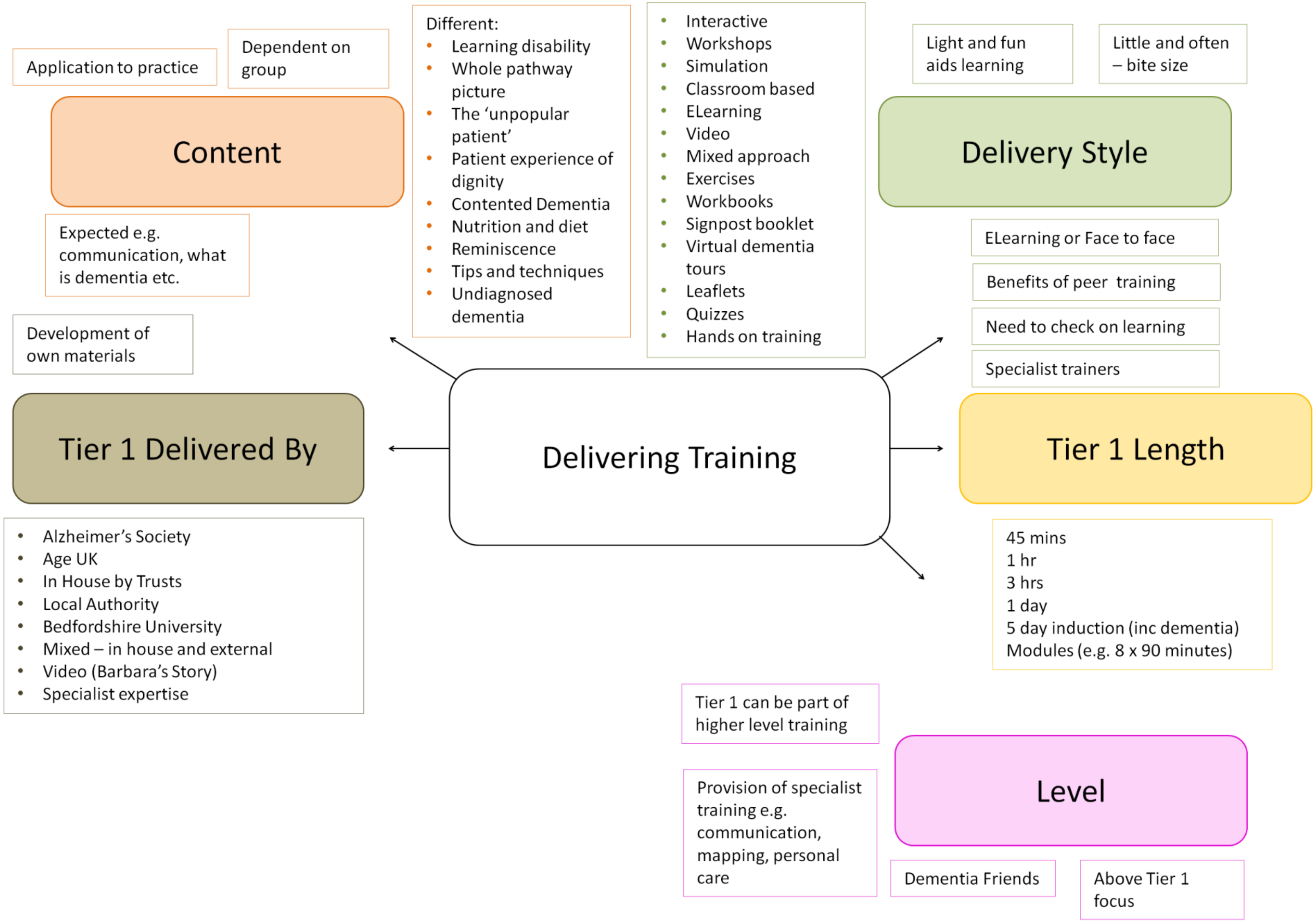
6.3.3 Length of training

Training courses varied in length from short 45 minute sessions to dementia being incorporated into a five day induction programme. Generally it seemed that the shorter sessions were more viable for the organisations taking part in this study and particularly for the dementia awareness level training.

6.3.4 Level of training

While the majority of the training discussed was at the Tier 1 level, inevitably, interviewees were also concerned with higher level training. Discussions were had about NVQ, City & Guilds training as well as more specialist training such as the SPECAL or Butterfly approach and Dementia Care Mapping.

Figure 8: Delivery of training theme map



Delivering Training

Content

Application to practice

Dependent on group

Expected e.g. communication, what is dementia etc.

Development of own materials

Different:
- Learning disability
- Whole pathway picture
- The 'unpopular patient'
- Patient experience of dignity
- Contented Dementia
- Nutrition and diet
- Reminiscence
- Tips and techniques
- Undiagnosed dementia

Delivery Style

- Interactive
- Workshops
- Simulation
- Classroom based
- ELearning
- Video
- Mixed approach
- Exercises
- Workbooks
- Signpost booklet
- Virtual dementia tours
- Leaflets
- Quizzes
- Hands on training

Light and fun aids learning

Little and often – bite size

ELearning or Face to face

Benefits of peer training

Need to check on learning

Specialist trainers

Tier 1 Delivered By

- Alzheimer's Society
- Age UK
- In House by Trusts
- Local Authority
- Bedfordshire University
- Mixed – in house and external
- Video (Barbara's Story)
- Specialist expertise

Tier 1 Length

45 mins
1 hr
3 hrs
1 day
5 day induction (inc dementia)
Modules (e.g. 8 x 90 minutes)

Level

Tier 1 can be part of higher level training

Provision of specialist training e.g. communication, mapping, personal care

Dementia Friends

Above Tier 1 focus

6.4 Gaps in training provision

Gaps in provision of current training was a key topic of the interviews, which focused not only on what content was perceived to be missing from training but also who should be attending the training, training provision gaps and what impacts organisational issues had on access to training.

6.4.1 Content and training provision

A range of training content was identified to be missing from current training. This ranged from specialist and more advanced knowledge on specific forms of dementia to more general knowledge about the care of someone with dementia. The topics identified were:

- Mental Capacity Act/Consent
- Undertaking capacity assessment
- Young people with dementia
- Cultural contexts
- Human aspect – emotional impact
- Communication – esp. with difficult behaviour, verbal and nonverbal
- End of life care
- Signs & symptoms
- Learning disability and dementia
- Behaviour
- Carer/people with dementia perspective
- How to support people
- Person centred care
- Drugs/ prescribing
- Positive environments
- Psychological care
- Ethnicity
- Signposting

In discussing the gaps in content, one interviewee also thought that the inner workings of brain function for dementia was not essential, as this individual stated, ‘I wouldn’t want to emphasise that at the expense of communication’.

The inclusion of more practical skills was particularly important, so that skills and knowledge could be easily transferred back into the wards, care homes etc. This was closely associated with the need to develop more confidence in staff through the training. The application of knowledge into practice was one way which interviewees identified that this confidence could develop. Training in general was thought to help develop confidence in staff.

‘… that they’re confident that they know enough about dementia to know this isn’t being caused by them… so it’s very practical… very practical.’ (Acute Trust)

The need to ensure staff continued to have updates and refreshers was important for some of those interviewed, but most agreed that on-going professional development was key.

Access to quality training run by experienced facilitators was also raised, with some questioning the accuracy and quality consistency of training provision. There were concerns that the range of training provision is not being properly reviewed and that what one training course delivers may not match other courses in terms of competencies or quality. The need for standardising training was clearly important to a number of those interviewed.

‘So it met a certain level… people who might be giving information on this but missing out that bit or they might not be communicating in the right things and might not be as up to date as, because there’s so much conflicting information out there anyway.’ (Care Home)

For another interviewee, accessing the knowledge of experts in the field to give talks and share their knowledge was an important way that training could be delivered, and another stated that 'I want an expert teaching it' (particularly for Tiers 2 and above). While another interviewee suggested there should be an accreditation for trainers.

'… there were lots of different people who could provide us with the clinical expertise we need.' (Ambulance)

As discussed already, a number of concerns were raised that dementia was only 'flavour of the moment', that the focus would shift and the momentum would be lost. As one interviewee discussed, in 'five months, six months down the line something else takes over and that's on the back burner'.

Another gap in the content of training, and more generally in the management of dementia care, was the need for signposting and clear pathways of care when treating people with dementia. This was discussed in relation to examples of other conditions, such as stroke or heart disease, where clear care pathways are known to services:

'… with heart attacks and major traumas [we] have a very defined pathway which makes it relatively straightforward to know what to do for our crews and which hospitals and where to go and the timeframes…'

This type of care pathway is not one which has been developed for people with a dementia. This was also related to seeing 'the whole picture' and end of life care.

6.4.2 Organisational impacts

Closely associated with the need for more signposting and clear pathways of care, was the need for collaboration between organisations or services. Examples were given of patients being transferred from one service to another and that when notes are not shared, the new service may not even be aware that the person in their care has dementia.

Organisational commitment to the delivery of dementia training was thought to be important and that messages needed to be seen coming from the top down, with senior management also accessing training.

'I think there is a group of staff that are not taking it up and that surprisingly is the more senior management staff… you actually have to have it from the top down.' (Acute Trust)

This engagement from the senior management was also discussed in relation to supporting organisational change and the delivery of quality care.

'You can't affect change en masse … if actually senior level are not signed up for it… it's actually about all of us and our attitude because the figures are great, but you can have great figures and really crap care.' (Acute Trust)

Gaps in the monitoring and recording of training delivery were also discussed by a number of participants. This is not regularly undertaken by most of those who were interviewed, with cost and time to undertake this identified as a barrier. One interviewee discussed how their organisation had carried out training for staff and not followed this up in practice. The organisation had also not been able to formally support the staff to implement their new knowledge in practice. The need to provide organisational structures to support staff to implement training was therefore seen as essential. This was noted particularly for junior staff who could be obstructed by more senior staff in suggesting changes.

‘… the junior staff go back in and they say ‘we’ve been on this training, we need to change this and we need…’ and the manager goes, ‘what do you know, don’t know what you’re on about, no we can’t do that here’… senior staff go on the training with junior staff to enable it to be put in practice, because what’s the point otherwise.’ (Local Authority)

A high turnover of staff was also thought to have an impact on the training delivery within organisations and on the care which patients/clients are receiving, with one interviewee calling it a ‘nightmare’ to train staff and see them leave within a few months.

Positive ways in which organisations are making an impact on care practices were also discussed and the use of the Alzheimer’s Society ‘This is me’ document to promote person centred care or the identification of patients who may have dementia are just a couple of the ways in which a more tailored care approach is being adopted.

6.4.3 Advanced training

The need for more advanced training was a central theme running throughout the interviews and was discussed at all stages. In terms of the gaps, interviewees wanted to find out about what training was available and that a directory of training would be useful. In addition, a gap in terms of level 4 training was identified, with a number of courses offering level 2 and 3 and 6 upwards, it was felt that the needs of those wanting to develop their skills but not have to undertake a degree course was missing.

‘There isn’t that level 4, in the middle… something that’s knowledge based, that’s a little more than the 3 but doesn’t mean I have to take three years out to do a degree.’ (Domiciliary Care)

6.4.4 Other gaps

The other main gap in training provision centred on who should receive training.
A range of staff roles were identified as gaps in training provision, those roles identified were:

- GPs, Neurologists
- Occupational Therapists
- District Nurses
- Senior management
- Frontline staff
- Administration
- Housekeeping
- Porters

In addition to the healthcare staff roles, family and informal carers and the wider community were also acknowledged to be groups who should be able to access appropriate training. While training for carers is delivered by some organisations, this is not a universally provision.

‘I feel that families need training as well. Because for us for carers to try and tell families, it’s very difficult because they don’t have the knowledge.’ (Care Home)

‘Because quite often what you’ll find is that the very people who need to know are the last people to know… quite often carers stuck in the middle actually doing the job of looking after somebody with a dementia, and they’re the ones that don’t know.’ (Charity)

6.5 Barriers to training

A number of barriers were discussed by the interviewees, with the cost of training and releasing staff time as the core issues. However, conflicting priorities, access to suitable training and the value of training were also identified as having an impact on the provision of dementia training.

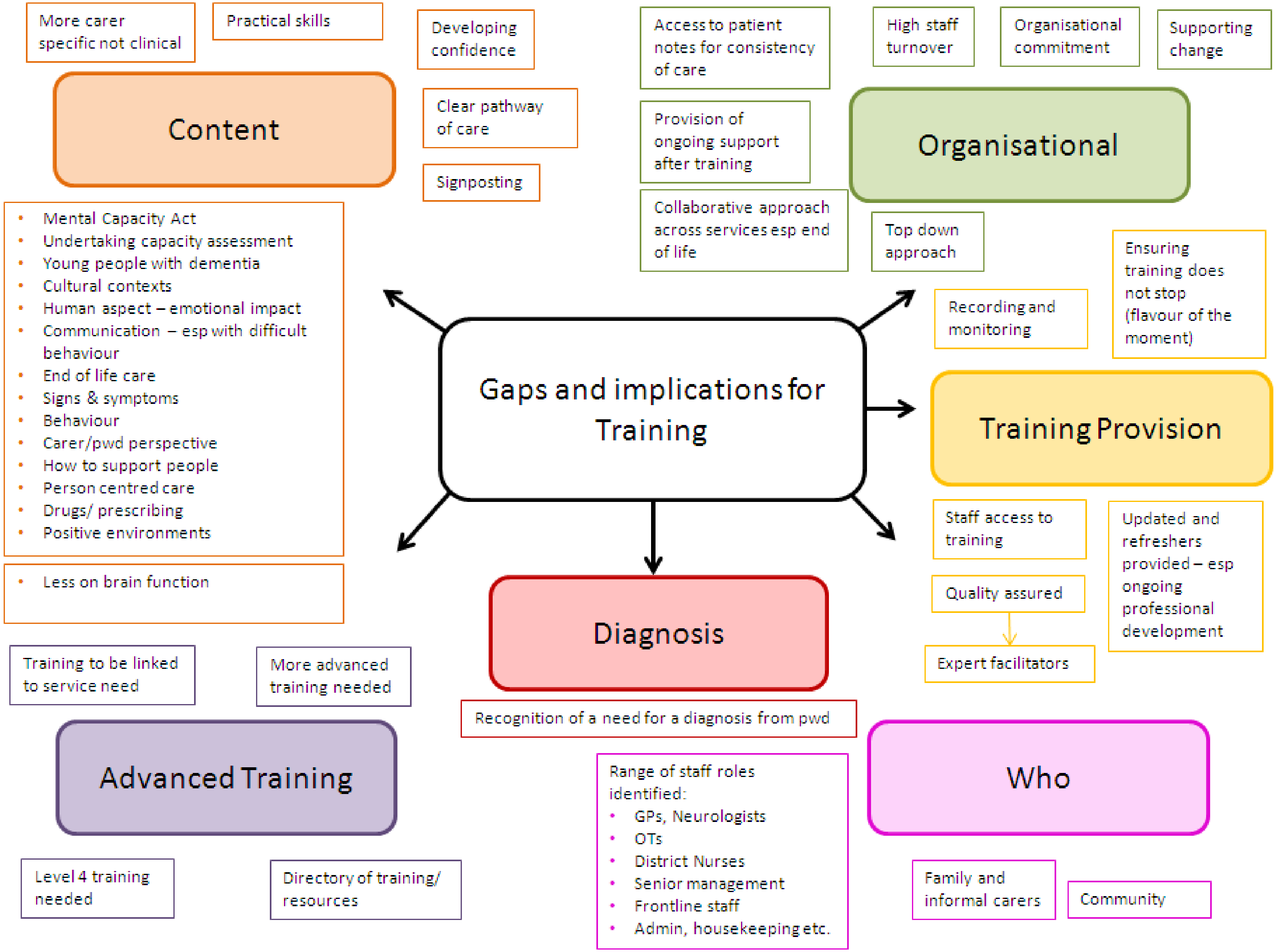
6.5.1 Cost

Cost of training was discussed in several different ways, primarily the cost of accessing external training provision and the cost to release staff to attend. There was also a debate about accessing quality training against the associated cost and that more cost effective ways of delivering training might be useful, for example train the trainer models.

Covering staff absences was an expense that a few interviewees discussed, as one individual stated, ‘they’ve still got to fill the gap and pay for the cover’. Not only is the cost of cover required but some training courses cost money and there are transport costs to consider, all of which can add up to a lot of money to send, potentially, one individual on a training course, ‘… so I’m paying three times for one certificate for one person’.

One of the interviewees discussed the use of financial incentives to cover for staff absences to attend training. One of the benefits of a funded project to deliver training to pharmacies, was to pay for cover for staff time. The reason for this was that many pharmacies, especially the independent companies, would not be able to afford for their staff to be released for a whole day.

Figure 9: Gaps and implications for training theme map



For one interviewee the balance between quality and cost was important, so getting 'the best I can for the lowest cost but the content's got to be good', was essential. Another interviewee discussed that quality was important and if that meant delivering only one course it was more important than delivering something cheaply. While for another the issue was about the cost of delivering training in-house, which was a cheaper option compared to the added value of accessing the more expensive external training. This individual recognised the need for higher level training to be delivered by those with expertise but was astounded by the cost of training.

'… you should be doing this, you should be doing that. I quite agree and then you see how much they're charging. £699 for a level 2 course, I swore. "No".' (Ambulance)

6.5.2 Time

As with the concerns relating to cost of training, a number of issues were similarly discussed in relation to time. Releasing staff from their day job was a key issue, which was complicated by staff absences and shift patterns. As one interview stated, 'there's never enough time to train everyone'. Further complicating the issue for this individual was the fact that training had to be balanced with delivering a job, 'people have to practice as well … they have to carry out clinical work as well as do training'. Creating this balance between a need to up skill staff and to ensure that the work is carried out was perceived to be difficult to do successfully. This issue was shared by a number of those interviewed, who reported that releasing staff and providing cover was complex and that 'ring fencing days' for training had an impact on the service delivery or incurred costs for overtime. The impact on staff to attend training was also noted by one interviewee, who remarked that staff have long shifts and can be exhausted by their day jobs.

'… it's more covering the staff going is probably the greatest issue, because they're all working flat out at kind of maximum levels, and yes, to release staff is not easy.' (Care Home).

'And so if someone phones in sick… it throws the whole rota into disarray and it makes it very difficult for people to be released.' (Local Authority)

One of the issues also raised was when training was delivered, that for different organisation different times were more suitable than others. However, a couple of organisations did suggest that advanced planning, although not a failsafe, would facilitate the delivery of training, so organising training several months, or even a year in advance was important.

'So notification ahead of time when dates of training are going to be is absolutely essential so that people can see, two, three months in advance and therefore people can make accommodation.' (Care Home)

'It needs very careful planning, everywhere is different.' (Acute Trust)

The difficulties of making training available at the right time was highlighted by one interview with a GP practice, where it was obvious that meeting the needs of just this one organisation was very difficult. It was identified that the doctors would only be able to access training on certain days of the week and at certain times of the day, however, this did not match the times which were most suitable for the practice nurses or the receptionists. In this example, the same training would need to be run on several different occasions to enable all staff to attend.

Associated with this was the length of the training. For most the short courses were preferable, as they could be fitted into lunch breaks or take place at the end of a shift.

> '… picking the time of day that's the most appropriate, when they're least busy, to release them for one or two hours, is really crucial to make sure you get maximum number of people attending.' (Acute Trust)

> '… you can only release people for a short time because their work has to be covered and there just isn't the time.' (GP)

Some training has been delivered outside of staff working hours, either in the evenings or weekends. While it seems that many staff are able to attend this training it has meant that for many this has taken place on their days off and that this time is often not paid for.

> '… some agencies where they expect staff to go in their own time. They don't pay them, which I think is appalling.' (Local Authority)

6.5.3 Value of training

The value of the training was important for a number of reasons. Firstly, in motivating staff to attend the training and for being able to see the benefit to the organisation, practice and the person with dementia. As one interviewee reported, 'value for patients, obviously… making it relevant to the staff… tailored to their level'. It was also reported by another interviewee that the value of the training is in learning new knowledge, and for the 'organisation to be able to show that they meet the minimum standard of training required'.

While another wanted to see an investment on their return, so that impact of the training was therefore an important factor. This return on time was identified by another interviewee who had experienced services asking 'what's in it for us?... we're not going to see the cash in the till'. The marketing of the training therefore becomes important in making sure services see the value of the training for their staff and for the bottom line. The way that training is advertised is also important and difficult, as one interviewee found in trying to raise awareness of her training with service providers. A range of different approaches were used, emails, direct mail, telephone call, all in an attempt to raise awareness and interest, as this individual states, 'it's just getting that message across without it just going straight in the bin'.

The way training is marketed also discussed as a way of engaging with staff, so that there is an interest generated in the training, which encourages staff attendance. One interviewee was aware of this issue and felt that those staff who were not interested in dementia were the ones who should be targeted.

Finally, sending staff on training who have an interest is also important to the value an organisation gains from the training, as one interviewee stated, 'it's no good sending someone who's got no interest'.

6.5.4 Access to training

The availability of courses was discussed by a number of those interviewed. This tended to centre on more specialist knowledge than the Tier 1 training which is at the focus of this study. However, this was a concern and shows not only a gap in the current training provision but is also a barrier to accessing training. As one interviewee pointed out, ‘but it’s accessing it, is it out there?’

Loss of funding for free courses was also discussed as a barrier to accessing training. This is in contrast to the feedback given from the Local Authority organisations who were interviewed, who reported to be delivering a range of free courses. This suggests that knowledge of training, knowing where to source training could be at the heart of the issue here.

6.5.5 Conflicting priorities

As has been mentioned briefly, conflicting priorities within organisations is a barrier to the delivery and access of dementia training. With a number of different mandatory demands on staff time, such as safeguarding and manual handling, fitting in dementia training can be quite difficult.

‘… because a lot of our protected time… is taken up with things that we have to do like with our anaphylaxis and things…’ (GP)

For services who offer more general care, this is perhaps a greater issue as the focus for these services has a greater range. As one interviewee commented, ‘we have to have a more wider, general approach to our training and at the moment that’s what, where it’s going’.

6.5.6 Language

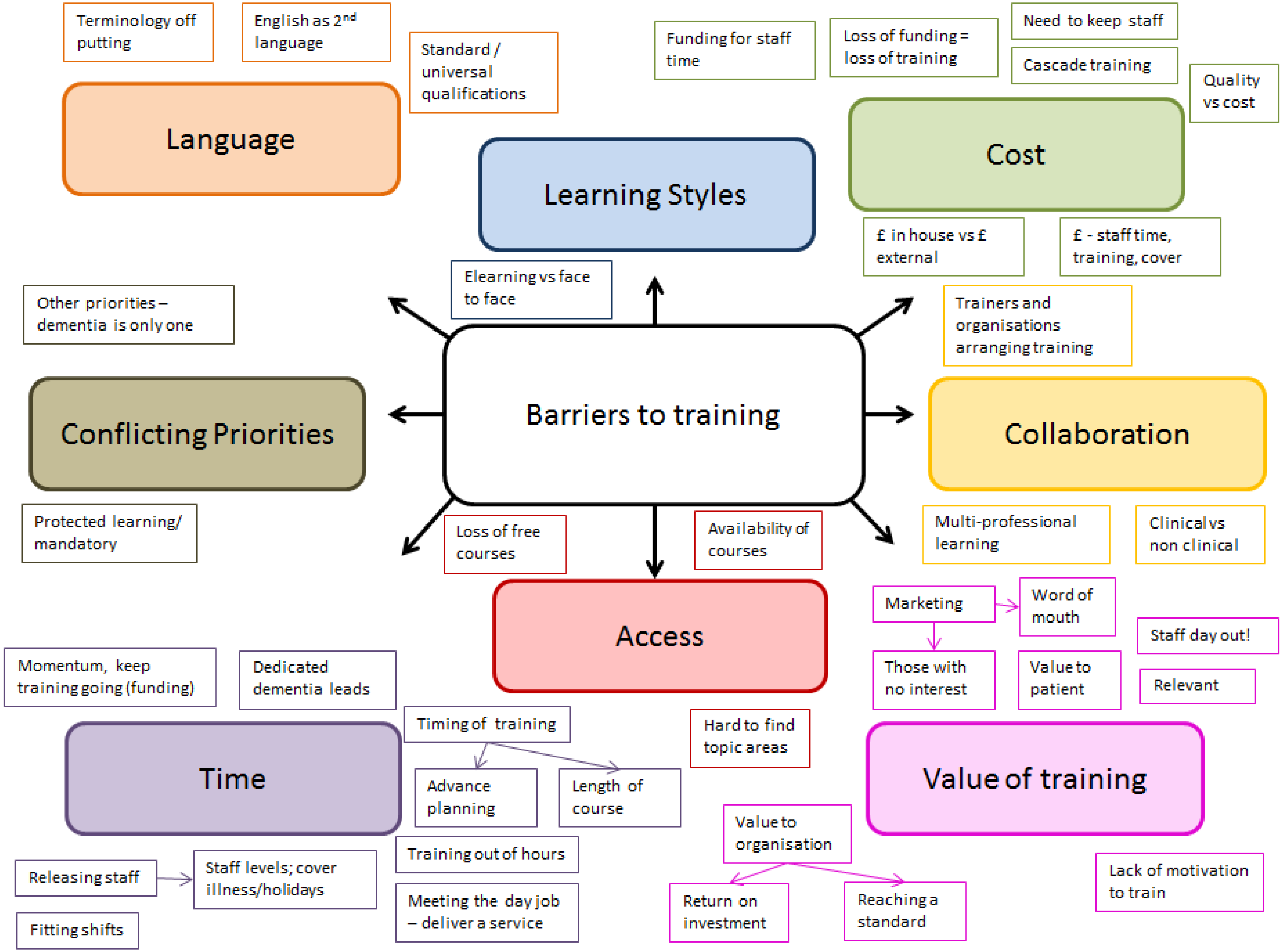
The terminology was thought to be a barrier to accessing training, particularly in relation to the learning objectives of training courses. One interviewee was annoyed that the same level of qualification meant different things for different training providers. So for City & Guilds level 2 is one thing but for QCF level 2 is ‘something completely different’. This is associated with the issues raised earlier about ensuring consistency and standardisation across the training in dementia but is also reflected in the way training courses are described and the use of consistent and clear language.

English as a second language and learning difficulties, such as dyslexia, were also raised as potential barriers to training and staff wanting to access training.

‘I think that’s probably the biggest one… language is an issue.’ (Local Authority)

‘… I’ve got people who are dyslexic and … English perhaps not their first language to start off with, so I have to take that all into consideration, that it’s going to be a little bit more difficult.’ (Ambulance)

Figure 10: Barriers to training theme map



6.6 Enabling Staff

Enabling staff to attend training was not just about being able to release staff for a period of time. Motivating staff, offering flexible training, career development opportunities and the chance to implement and share knowledge were vital to the training being offered to staff.

6.6.1 Motivating staff

Motivating staff to attend training was discussed in a number of different ways, by making them feel special in attending the training, relating the work to practice and also in ensuring a quality product which led to new knowledge.

Training which delivered ‘something new’ in terms of knowledge learning and which led to implementing this knowledge in practice was thought to be particularly important. One interviewee thought that staff attending training should be able to discuss what they learned with colleagues, to share the knowledge and to be able to implement change within practice as a result. The real value of the training was thought to be through this process.

‘… is it something I’m going to be able to use in practice, is it something I’m going to be able to share and change and be a change tool for the Trust.’ (Acute Trust)

The links to practice were supported by other interviewees who saw the benefit for real and implementable knowledge. It was suggested that training carried out on the job or within the workplace had particular value as the practice and learning connections were made during the training. While another interviewee talked about the benefit of ‘embedding’ training within practice.

‘… and generally they are [motivated] when they’re getting something that’s different and interesting and based around what they’re doing in their everyday job, they seem to enjoy expanding their minds and helping them to gain the knowledge to work with the service users.’ (Domiciliary Care)

This was also discussed in relation to being recognised for having gained knowledge in dementia by colleagues and patients. One Trust has employed a badge system whereby staff who have been trained wear a badge as a form of recognition to others, one of which was noted by a family member who recognised the difference in patient care received by the trained nurse and those who did not wear a badge.

‘The Health Care Assistant had a very different approach to managing her husband, and she recognised that she had this Pin Badge, and asked what the Pin Badge meant. And could absolutely identify that that person had had additional training. The Health Care Assistant involved was very proud of the fact that she had a Pin Badge that showed that she'd had this additional training. Then when we were able to feedback and actually say:

"You made a real difference to the patient and their relative."’ (Acute Trust)

The quality of the course is also an important way to motivate staff. This was thought of in terms of the content, facilitation and the venue/facilities. So the provision of lunch and the ability to network with other attendees, for example could support the overall experience of the training. Interviewees commented that the venue should be ‘relatively easy for staff to get to’ or delivered in-house, that staff should be made to feel special, as one interviewee commented, '… part of the training is they have to be fed and the venue has to be nice'.

6.6.1.1 Career and professional development

The provision of training which leads to 'increasing skill and specialist knowledge' was an important aspect of the training being delivered, especially if this was associated with qualifications or certifications. The emphasis of professional development was a central concern for a number of participants. One interviewee stated that 'career development is massive', another valued training which led to staff having 'a bit more responsibility' and another discussed the significance of training with CPD hours for their staff. The value of having a certificate at the end of the training was also noted by one interviewee, who saw this as a way to encourage staff.

'Got to have the CPD hours element of it so it's good for the registered staff.' (Dentist)

'… really good eLearning will encourage staff… and they know when they have finished and they can print off a certificate.' (Acute Trust)

'… we're very clear with them about how it links into the qualifications and credit framework with our training,… So that people can see how it ties in with their development of their career.' (Local Authority)

Accessing NVQ level training for one interviewee, although not necessarily in dementia training, was highlighted as having led to a number of benefits for their team. The NVQs resulted in the development of new policies, procedures and standards. This is an example of how training can have a positive change on a department and lead to the change, which a number of interviewees were alluding to.

It was also discussed that training should build staff confidence to do their jobs well, as one interviewee reported:

'I want my staff to be happy in the training that they're getting and confident in it so that when they do go out, they have the confidence and competence to actually go and deal…'

6.6.1.2 Shared knowledge

The opportunity to get to know people on the training course and to share experiences was thought to be an important aspect of the learning process.

'And they get to know each other a bit better.' (Care Home)

'multi-disciplinary, it's good to relate to other services…' (Dentist)

'… meet with other staff, and I think then can, a problem shared is a problem halved really… you can give your ideas and listen to other people's ideas.

Because probably in the home environment, all the staff have got the same problems and it's nice to listen.' (Care Home)

The sharing of knowledge was also discussed in terms of bringing the knowledge back to the team, of passing on the knowledge and developing the whole team.

'Because if staff feel that what they're doing is worthwhile, that they're valued, then that will be passed on.' (Local Authority)

Finally, sharing knowledge within teams was not the only way that this shared approach to learning was considered. One interviewee was also very keen to develop training material which could be shared with other health professional teams and services. As they stated:

'it's not just for us, although we will really benefit from it, we'll be sharing the materials and hopefully making them relevant to colleagues, nurses, midwives and mental health workers'.

This stresses the need for a collaborative approach to dementia training, not least because different disciplines can learn from each other, but also the sharing of resources and training materials could provide a cost saving for services.

6.6.2 Flexible training

The actual running of the training was important to a number of those interviewed. The discussions focused on a number of areas, particularly, in providing a range of training to suit different learning styles.

The delivery of training was discussed as a way to motivate and enable staff to learn, for example the use of 'interactive and fun' exercises, or through a mixture of face-to-face or eLearning. With staff at different levels of experience and backgrounds, offering this mix or 'choice' of training was an important way of being inclusive and encouraging staff to attend.

'We try to facilitate as much as possible, so we'll run eLearning drop in sessions so we can help people through it but also run face-to-face sessions, bespoke sessions for particular staff groups.' (Acute Trust)

'… so the variety of, meeting all the learning styles, so the offer of distance learning, but if you're going to be sat in a classroom, let's make it interesting.' (Domiciliary Care)

'And different staff groups might engage more with the video whereas some people might like the podcasts…' (Ambulance)

One interviewee discussed the delivery of training material in terms of using technology to offer 'bite size bits' to staff, through podcasts which are accessed on iPads or other work devises. In this way, messages, tips or thoughts of the day could be delivered on a regular basis, building up people's knowledge but also being delivered in a way which does not intrude upon their work time, this is something that could be accessed when they are 'stood down'.

‘… so thoughts of the day, the tips for dementia, the little evidence based helpful hints could be sent through on that screen…’ (Ambulance)

Supporting staff who have English as a second language was also related to a flexible approach to training. A couple of those interviewed commented that extra support might be needed for such staff, with one providing English classes to ‘optimise’ their learning.

One interviewee summed up the purpose for motivating staff to attend the training and why these different approaches are necessary, stating, ‘if it sparks an interest and enthusiasm for finding out more, that would be great’.

6.7 Monitoring training

Not all those interviewed undertook monitoring of the training within their organisations. It was not always clear how monitoring would be best undertaken and some were concerned about the cost and time implications that this would have.

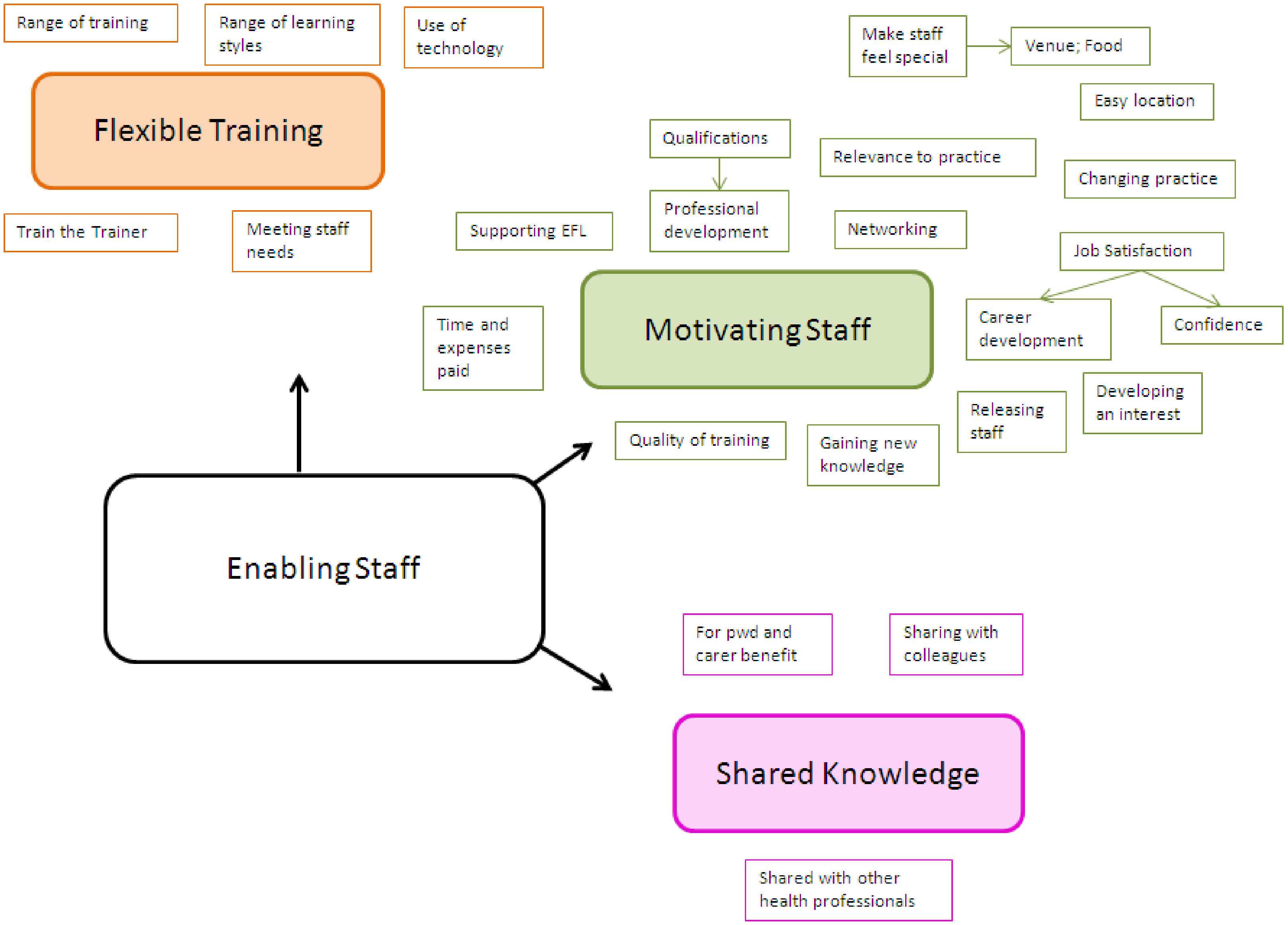
‘… has it changed practice and has it improved patient outcomes? And it’s really quite a hard thing to prove.’ (Ambulance)

One service requested support with measuring the impact of training through this study – ‘… that could say how we may have improved outcomes by training … I would welcome that approach’.

One organisation discussed a very formal approach for staff to apply for training, completing a business case with learning outcomes; this was then not followed up after the training. As the interviewee reported, ‘… we never go back and say how well… did that individual apply that to the job. We just haven’t got the capacity to do that.’

However, there are a number of ways in which training is being monitored and suggestions made for how this process could be undertaken. What was central to this debate on monitoring, was to try to measure the impact training had on practice.

Figure 11: Enabling staff theme map



6.7.1 Staff measures

A number of staff measures are being used by the services interviewed which were suggested as ways to measure the impact of training. Such measures include: staff absences, staff attrition, staff requests for training and staff confidence.

‘I think it’s in the way that they carry themselves, it’s the way that they talk, it’s the way that they feel about themselves and the measure of their confidence…’ (Acute Trust)

‘… particularly at the attrition of staff to see whether staff attrition is impacted by better training and therefore people are less stressed, more confident.’ (Care Home)

‘… you know, people say to me, ‘What else can I do?’…’ (Ambulance)

As well as measuring the impact of the training on staff morale within an organisation, the impact on their knowledge was also important. Interviewees discussed various ways of measuring this, for example some were supportive of using pre and post work around the training course, so that staff had to prepare materials prior to attending and then had homework afterwards, particularly making this focused on their practice. This was then monitored through a follow-up with the training lead or manager.

‘… we ask the participants to go away and complete a Alzheimer’s Society ‘This is me’ document or a life history document… to learn something new about their resident that would impact on the care that they give.’ (Care Home)

One organisation also used formal exams and testing with their training, expecting staff to achieve a certain pass grade before being able to continue with more advanced training. Following up the impact of training with managers was standard across a number of organisations, either through supervisions, reviewing personal development plans or through feedback at team meetings. Some staff were also reported to be encouraged to use reflective practice, following the care of an individual over a set period of time and reflecting on how this care was implemented and managed.

‘Once back in practice then managers via one to one or supervision look at learning needs.’ (Local Authority)

‘The personal development plan is supposed to help reflection and feedback. The person will reflect if a particular course helped them in their work.’ (Acute Trust)

6.7.2 Practice monitoring

A range of practice monitoring was also discussed. For example, it was suggested that this could be measured through the number of complaints made by clients/patients, use of antipsychotic medication, patient and family feedback, the number of problems staff report about delivering care or requesting additional support, for example through dementia care mapping.

‘… when I first started here… I got nothing but complaints. The phone wouldn’t stop. Now I can’t think of when the last complaint happened… sickness as well… when you introduce the NVQ amazing… I can’t remember the actual figures, but it was hundreds of hours of sickness absence, disappeared.’ (Acute Trust)

‘… I will be requested to go in and do either a dementia mapping or a complete resident review… and I monitor the number of residents per community that I’m now requested to go to. And that’s a more effective measure because that is definitely reducing.’ (Care Home)

The understanding of how patients/family members felt about the service delivery was also important, making sure that the ‘experience’ for the person with dementia is ‘better’ and how best to measure this was a central part of the discussions.

Measures of staff skills were also suggested, through in formal and formal observations or on the spot assessments. In addition to this, care plans and staff notes are reviewed and assessed.

‘… most of its visual measurement, you’re watching what happens.’ (Care Home)

‘we observe the person in the care home working with the person who has dementia. And the notes that they have, so we look at people’s care plans, daily notes, whatever, and assess if they’re competent in working.’ (Care Home)

‘… once they’ve been back in the workplace and see how they’ve applied the learning.’ (Local Authority)

‘And I assess them all. So if they’ve done training on X, then a few months later I will assess them on X...’ (Ambulance)

Where training is conducted within the workplace, there is the opportunity for instant measuring and feedback. This was something a couple of those interviewed discussed positively, as this provided staff an opportunity to learn on the job and to practice changes immediately.
One of the concerns expressed about the monitoring of training and one area where it might be lacking, was the way that understanding could and should be checked after eLearning.

‘I know its and easier way to train numbers of staff, but there still needs to be some checking of understanding.’ (Charity)

6.7.3 Evaluation of training

The evaluation of training courses were undertaken by a number of the organisations interviewed. This was usually through a process of feedback questionnaires, pre and post knowledge questions or informal feedback from staff. It was acknowledged that on the whole this type of evaluation does not measure the impact of the training, but rather ‘it’s more whether people had a nice time’. For some this was also about monitoring which and how many staff were undertaking the training.

‘… I would get feedback on how I trained, how the staff felt I trained and also on how useful they found it.’ (Acute Trust)

‘We have evaluation forms that we … get participants to fill in after every session,… we look at their overall satisfaction, whether they feel that their knowledge has improved, what areas they think we should improve...’ (Acute Trust)

One interviewee reported that alongside the course feedback, their staff were also interviewed to gauge the value of the training.

‘… but then I interview them after the course and we go through on a one-to-one and I say … “What was good?”’ (Ambulance)

One interesting point made was the difficulty to evaluate training which was undertaken by staff accessing the range of training material on YouTube. This is often carried out in spare time and not reported as being completed. Therefore organisations are unaware that these resources have been accessed and so cannot monitor their impact.

6.7.4 Contact monitoring

Some formal auditing processes are also being undertaken by services and quality measures are being put in place to monitor dementia care. For example, one interviewee discussed the use of a clinical governance framework and a dementia quality audit which is part of a 12 month action plan. These incorporated using simple measures such as how many staff have been trained, but also include standard quality indicators, such as pressure sores, chest infections, the number of incidents of aggressive behaviour and incidents of safeguarding being reported. More formal approaches to the monitoring of training were also evident where external organisations are being commissioned to deliver training. In these instances it seems that training is closely monitored.

‘We have the contract monitoring officers, so the organisations that we commission with, they are monitored. So they go out and they will see the kind of practice, have a conversation with a care worker and ask to talk to managers abut training.’ (Local Authority)

6.8 Tier 1 definition

A number of those interviewed thought that the current Tier 1 definition, as defined by Health Education England, was ‘clear’, ‘very good’ and ‘useful’ and was appropriate for supporting the development of a basic knowledge of dementia.

However, this was not universally agreed by those interviewed in this study. There were a number of concerns about the wording used, particularly the use of the word ‘managing’ which had connotations with the use of drugs and ‘controlling people’ and was seen quite negatively. The definition was also thought to imply ‘clinical responsibilities’, which was not thought to be appropriate for dementia awareness level training.

The identification of signposting was also identified as an issue, while being a useful inclusion, it was not clear how this would be managed practically in a changing landscape of service provision and across the different geographical locations.

‘The signposting aspect is important but so much changes so quickly that it’s hard for anyone to keep up with all the different agencies…’ (Local Authority)

Others thought that the definition was too broad, too ‘sweeping’ and ‘woolly’ and did not include information about benefit entitlements or interactions with people with dementia and their carers. Additionally, non-diagnosis and the inclusion of the family, carer was thought to be missing.

‘It makes the assumption that we know who has dementia, often staff deal with patients that don’t have a diagnosis.’ (Acute Trust)

‘That’s quite a sweeping statement, recognising and understanding dementia, … I’m still trying to understand it after many years of working in the field of dementia.’ (Charity)

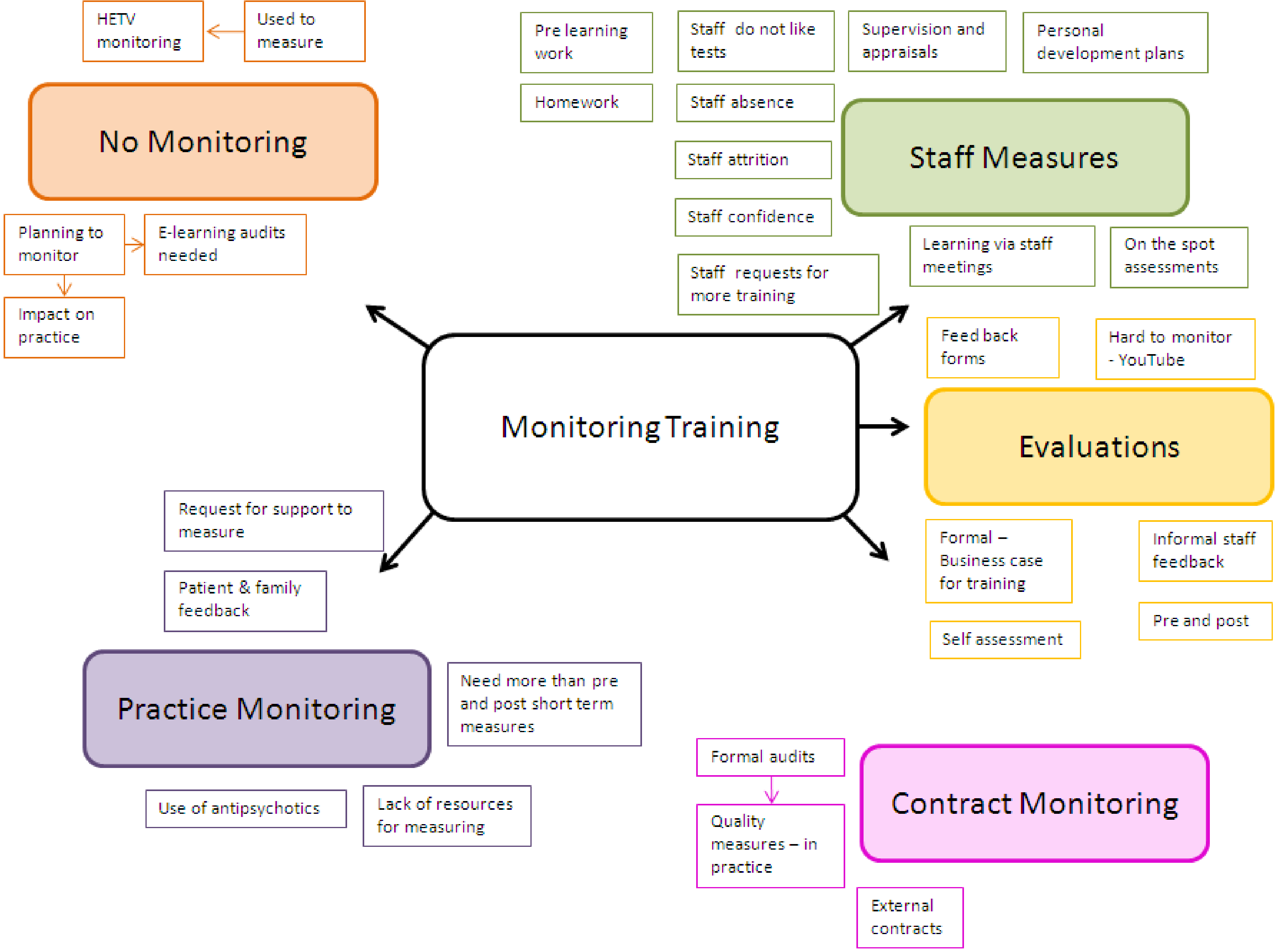
A couple of interviewees commented on the distinction between training and awareness and what the actual goal of the government’s mandate was. Training had a very specific meaning, relating to standards and qualifications, while awareness was something that they related more to developing community knowledge.

‘Awareness is within the community, training is formal with aims and learning outcomes and then you practice in your work environment.’ (Charity)

Finally, there was a need to ensure that staff were not made to repeat training when they already had a sufficient level of knowledge. The need for the Tier 2 and 3 definitions was also noted.

‘… but there are large groups of staff that have exceeded this level of training so how do we capture these ones and don’t expect them to repeat training below a level they have already achieved.’ (Acute Trust)

Figure 12: Monitoring theme map



6.9 Strategic leadership

The discussions about strategic leadership focused on the Tier definitions and the need for clarity and definite definitions. The concerns were that with the Tier 2 and 3 definitions still not finalised, organisations did not want to undertake training to find out that this would have to be re done as it did not meet the Tier 2 and 3 objectives.

‘What we wouldn’t want to do is prepare everybody and then found that we’d missed a key point…’ (Ambulance)

‘The lack of national competence requirements are a huge concern, as we can’t have people released to attend training, … and then find out that it doesn’t met the criteria…’ (Acute Trust)

This was also related to the targets which have been set by Health Education England, which were not thought to be as clear as they could be.

‘We feel frustrated when we have to report our figures, we like to achieve and demonstrate that we are doing well, which is quite difficult when it’s so vague.’ (Acute Trust)

There was also a concern that the targets were just about the number of people trained rather than the quality and the impact on practice: how was this to be measured?

Finally a collaborative approach which could be supported by strategic leadership was also discussed, with interviewees wanting to have a shared and joined up approach to training delivery. There was a strong awareness that there are a number of services providing different training and doing similar work, but that these are not being joined together to provide a more coherent and systematic approach to the delivery of dementia training. This was thought to be true of the delivery and development of training but also in terms of the funding different organisations had access to. One interviewee thought there was a need to ‘… prevent replication but encourage complimentary activities’, and in so doing, reducing workloads and helping to ‘sustain services and business as usual but doesn’t cost the earth’.

6.10 Dementia friends

The use of the Dementia Friends training was discussed by some of those interviewed. The Alzheimer’s scheme was discussed in a positive way, on the whole, but there was recognition that it was not suitable and did not meet the requirements for Tier 1 training. As such a number of those interviewed had not engaged with the scheme.

However, the scheme had been endorsed by some and one organisation had cleverly incorporated it into their dementia awareness training so that all their staff were being trained at the appropriate level but were also becoming Dementia Friends. This particular organisation were ‘very proud’ of their involvement in this scheme and of encouraging links with their communities. So the aim was to now become more engaged in the dementia friendly communities and help support dementia awareness through coffee mornings, engagement with other businesses and community members.

This was not the only organisation to be engaging with their local community, another of whom were also delivering dementia awareness talks, and as they stated, ‘it’s a good way of blending in with the wider community’.

Other organisations thought that the training was a good way to provide a lower level of awareness to some of their staff, for example administrative staff and volunteers.

6.11 Final thoughts

The interviews covered a wide range of themes, of which similar issues cross cut and were woven across the discussions. The need for clarity of the Tier definitions and for a consistent language in describing training provision came through strongly. In addition, the need for a varied approach to training was emphasised alongside quality of the provision. The need to link training with career development and professional practice was also a priority and in ensuring that there is a positive impact upon the care that people with dementia receive.

The distinction between clinical and non-clinical training provision was raised on several occasions, this was in terms of the type of training different groups of staff should be accessing, so a flexible approach to learning styles and content was required. This was also discussed in relation to which staff should access training. Most of those interviewed thought that all staff should receive training but this was not agreed by all. For some, the focus was on the clinical staff and training for non-clinical staff was not thought to be a priority.

The learning points from these discussions is taken forward in Sections 11 and 12 which provide a summary of the main conclusions from this scoping review and provide recommendations for practice.

Figure 13: Tier 1 dementia awareness definition theme map

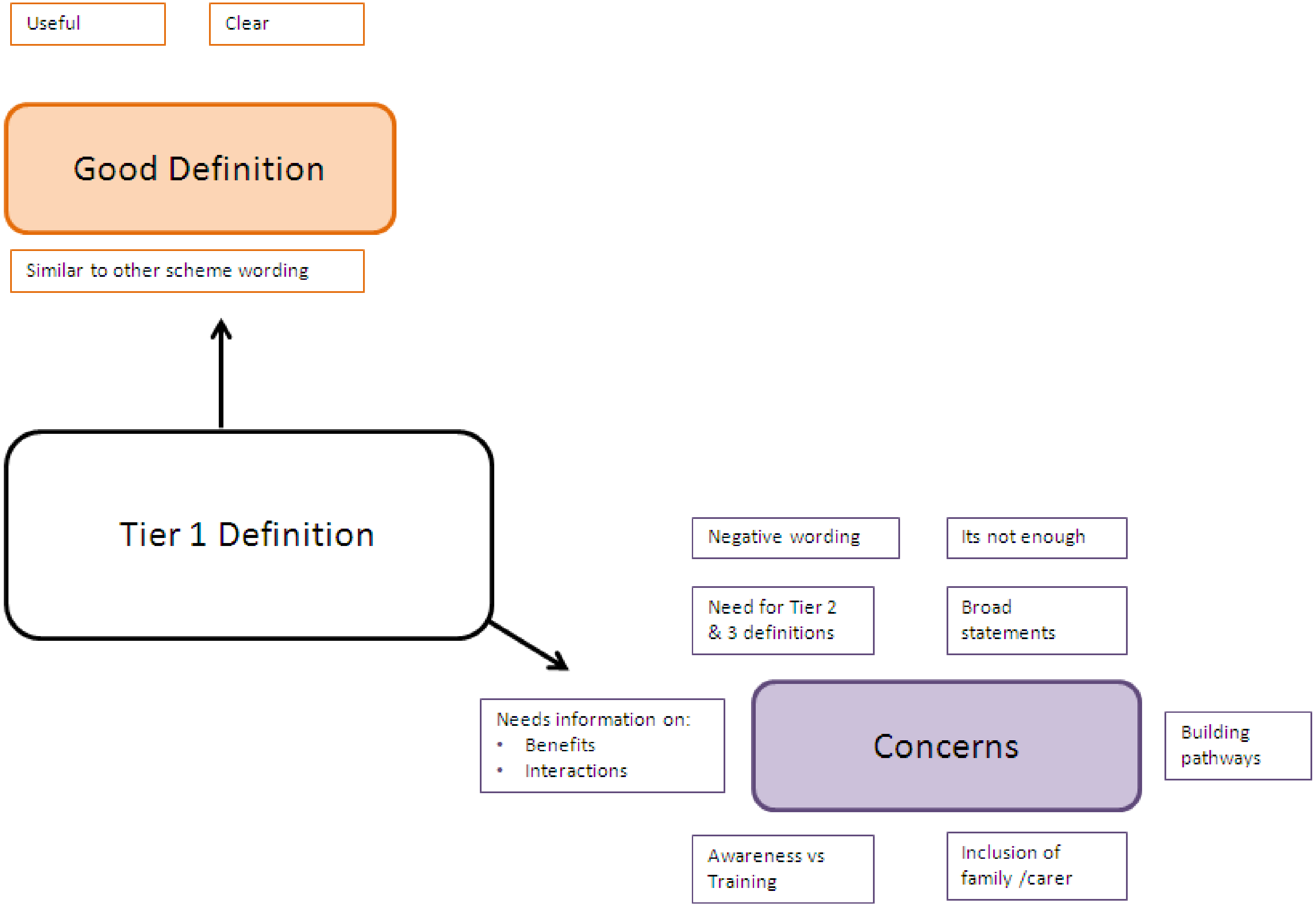


Figure 14: Strategic leadership theme map

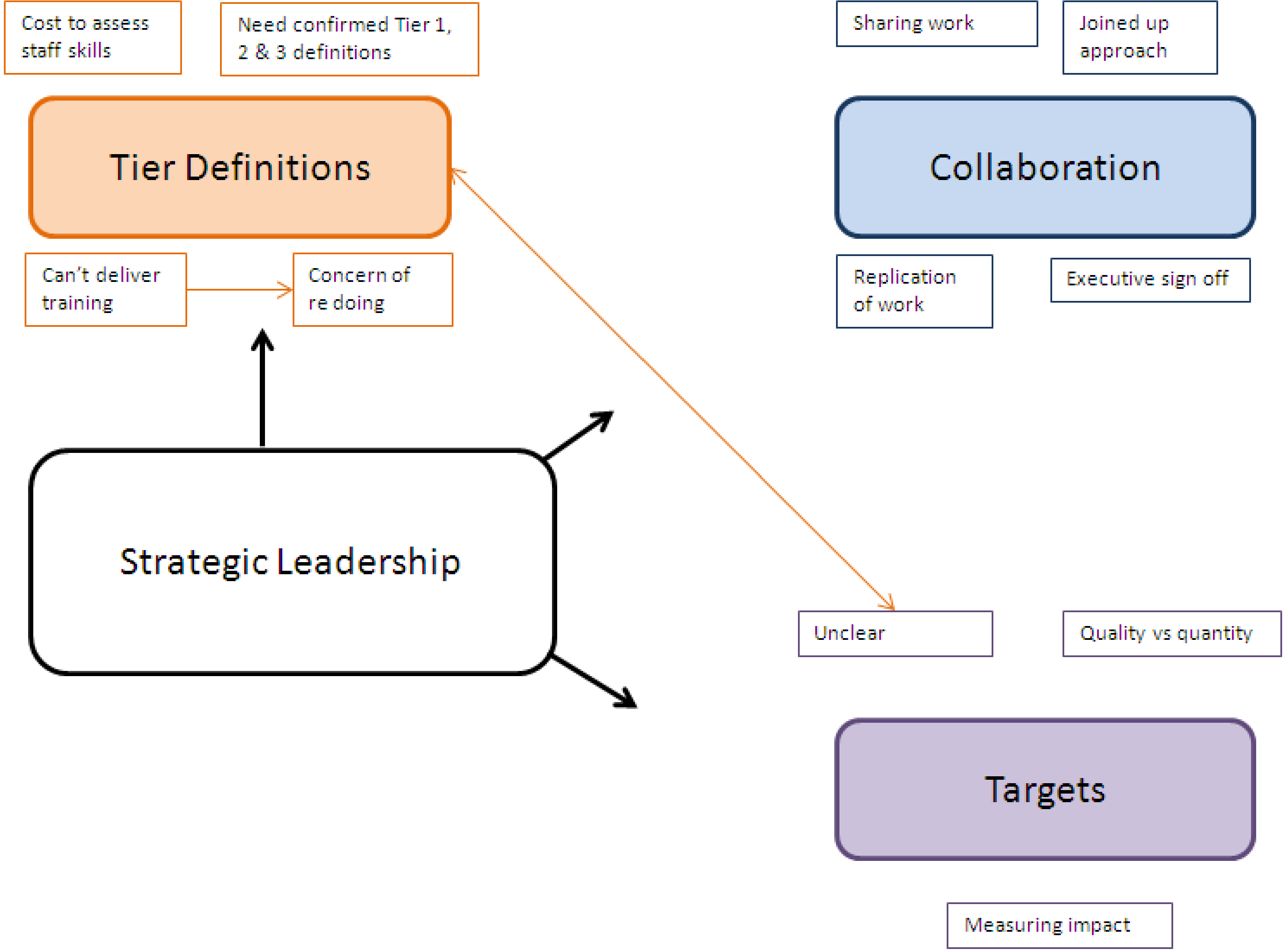
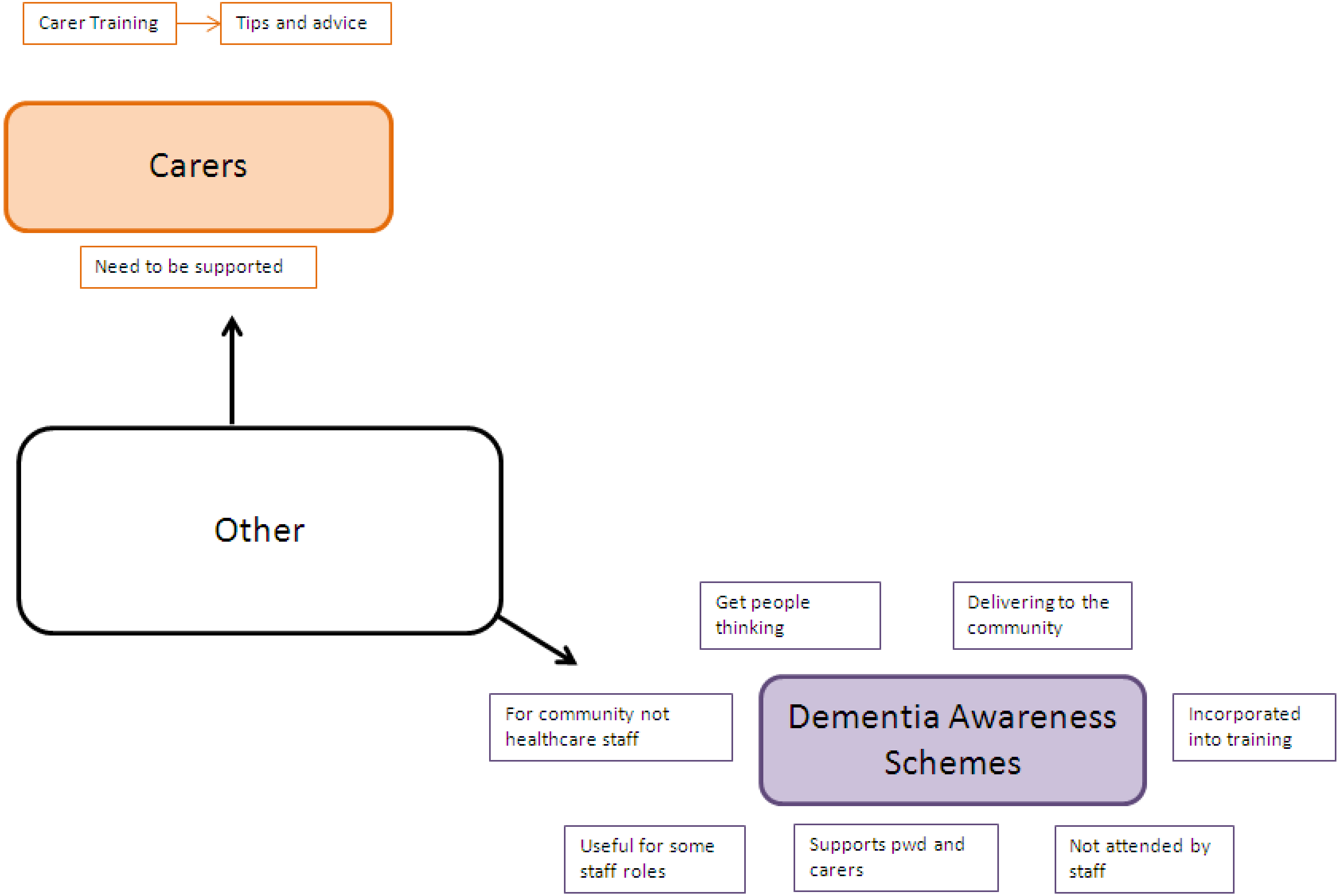


Figure 15: Other issues theme map



7 Training document review

This section presents the findings from the training document review. Data was collected from a range of different sources and via different approaches, including desk based research, contacting organisations directly, through interview data and the research team/commissioner knowledge. These represent the training courses which are available to NHS staff in the Thames Valley Region and nationally. In total 99 training courses were identified, of which 59 were identified at the Tier 1 level. The learning outcomes of each course were mapped against the Dementia Competency Framework as developed by South West Dementia Partnership and the Tier 1 Dementia Awareness Competencies as developed by London Dementia Strategic Clinical Network.

It should be noted that while the research team were able to access detailed information for many of the courses identified, for some the information was not publically available and the information has been mapped against core learning objectives only. The data presented in this section may therefore not reflect the full range of topics which these training courses deliver. However, this does present a valuable resource in terms of understanding the range of training currently available, their core learning outcomes and how they map against national competencies.

What should also be noted is that this report is being presented in a climate of change for dementia training delivery. The definitions of Tiers 2 and 3 are still being determined and the Department of Health’s dementia awareness eLearning provision and Worchester University’s Stand by Me training are being reviewed. At the same time, Skills for Health have launched a new Skills for Health Quality Mark for the health sector, which will provide a framework for ensuring training meets set standards. Finally, Health Education England commissioned a study to embed dementia training into HEI health education from September 2015. The project aims were to provide guidelines for ‘educational programmes to improve dementia diagnosis rates and enable support staff to provide safe, dignified and compassionate care of people with dementia’ (University of Exeter, Medical School, 2014). The report for this project was not available at the time of writing.

7.1 Dementia competencies

At the time of the review two key documents were used in this study to outline the dementia competencies for Tier 1 dementia awareness. These were:

- South West Dementia Partnership (2014) Dementia Competency Framework.
- London Dementia Strategic Clinical Network (2014) Guide to Dementia Training for Health and Social Care Staff in London Improving quality of care.

It should be noted that these have since been updated and the Tier competencies are outlined in the Dementia Core Skills Education and Training Framework (SfH, EE & SfC, 2015).

The core competencies from each of these documents are mapped in the following figures.

Figure 16: Summary London Dementia Strategic Clinical Network Core Principals

Core Principals

- Understanding of what dementia is, prevalence and impact.
- Awareness of the common signs and symptoms of dementia, e.g. memory problems, confusion and communication difficulties.
- Knowledge of how to access local community information and services that can provide information and support for people with dementia and their families and carers.
- Knowledge of a range of communication and interaction methods to suit people who are experiencing confusion, memory or communication difficulties.
- Understand that a good and valued quality of life should reflect the priorities of the person with dementia, their family and carers.
- Understand what is meant by the term person-centred support in relation to people with dementia.
- Understanding of the experience of dementia.

Figure 17: Summary South West Dementia Partnership Core Principals

Core Principals: Essential

- Promote an information culture & promote health and wellbeing

- Understand and be able to describe dementia
- Know the most common types of dementia and their causes
- Understand factors relating to an individual's experience of dementia
- Introductory awareness of models of disability

- Support individuals to access and use information
- Work in collaboration with carers in the caring role

- Understand the factors that can influence communication and interaction with individuals who have dementia
- Communicate effectively in a healthcare environment
- Understand how a person-centred approach may be used to influence positive communication

- Assist the practitioner to implement healthcare activities
- Understand and implement a person centred approach to the care and support of individuals
- Provide information and advice to support individuals in undertaking desired occupational and non-occupational activities
- Develop practices which promote choice, wellbeing and protection of all individuals
- Contribute to support of positive risk taking in everyday life

- Understand how to respond to behaviours that can challenge those supporting through person centred approaches

- Awareness of other agencies providing support

- Contribute to promoting a culture that values and respects the diversity of individuals
- Understand key legislation (Mental Capacity Act, Deprivation of liberty)
- Contribute to the protection of individuals from harm and abuse
- Understand safeguarding
- Ensure your own actions support the equality, diversity, rights and responsibilities of individuals
- Comply with legal requirements for maintaining confidentiality in healthcare

- Synthesise new knowledge into the development of your own practice

These competencies cover the reach and expectations for Tier 1 dementia awareness training and should be achieved in order for training to achieve the Tier 1 level.

In translating these competencies to the training documentation reviewed, five overview competencies were identified, with sub competencies. In addition, several other topic areas were identified from the documentation, all of which are detailed below:

- Theoretical Models of Understanding Dementia
    - Able to describe dementia*
    - Signs and symptoms*
    - Types of dementia and causes*
    - Brain function•
    - Treatments/medication«
    - Diagnosis«
    - End of life care«
    - Social/Medical model«
    - Fact vs Fiction«
- Awareness of Dementia
    - Awareness of disability model•
    - Prevalence and impact°
    - Understanding the experience of dementia*
    - Risk factors – health promotion•
    - Behaviour•
- Communication and Support
    - Communication - meaningful interactions*
    - Supporting people with dementia*
    - Supporting/working collaboratively with carers*
    - Supporting Health and Emotional wellbeing•
- Person Centred Care
    - Person centred care*
    - Signposting*
    - Advice/guidance*
    - Understanding the Impact on family°
    - Supporting Healthcare activities•
    - Environment«
    - Promote an information culture•
    - Promote independence/choice•
- Ethical practice
    - Advocacy/Safeguarding•
    - Mental Capacity Act•
    - Strategy/Policy•
    - Diversity•
    - Using Knowledge in practice•

**Both competency documents*
«Training documents
•South West Dementia Partnership (2014) Dementia Competency Framework.
°London Dementia Strategic Clinical Network (2014) Guide to Dementia Training for Health and Social Care Staff in London Improving quality of care.

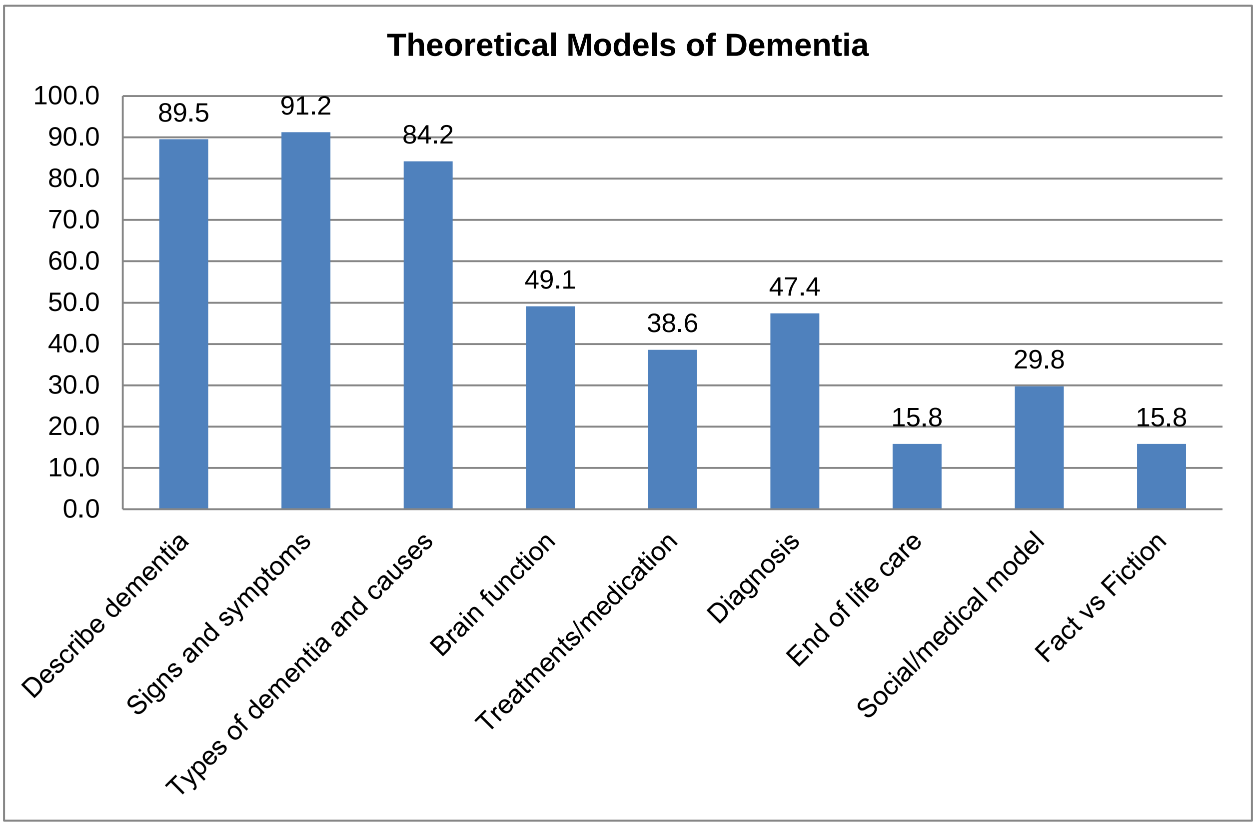
7.2 Dementia awareness training

The findings from the 59 Tier 1 level training documents are presented in this section. As discussed, these findings are based on the documentation made available to the research team via the interviews and desk research. Information about four training courses was very limited and it was not possible to match the outputs to any of the competencies. These four documents have been excluded from the data analysis. This review therefore includes the data from 57 documents.

One of the difficulties in mapping the training documents to the competencies is that often training objectives refer to attendees understanding ‘what is dementia’, this is a broad term which was not easy to capture in the mapping exercise, given that it could include a number of competencies from types of dementia, symptoms, brain function etc. For this mapping, the term was taken to incorporate: being able to talk about dementia, signs and symptoms and types of dementia. Brain function was only mapped if specific mention was made to this within the training documentation.

The inclusion of topics around the theoretical models of understanding dementia were the most reported of all the topics mapped in this exercise. Being able to describe or understand dementia (89%), signs and symptoms (91%) and types of dementia (84%) were the most prevalent across the training courses. It is likely that these figures are higher but these figures are based on the information available. Few of the courses covered end of life care (16%) or looked at the treatment of dementia (37%).

Figure 18: Training document review: theoretical models of understanding dementia



(Base: 57)

When looking at the topics which are grouped under awareness of dementia, understanding the experiences of dementia was referred to by just over two thirds (67%) of the training materials reviewed, and nearly two thirds included consideration of behavioural changes/challenges (63%). Risk factors for dementia and prevalence and impact were evident in 50% of the documentation. While only 14% made mention of the disability model.

Figure 19: Training document review: awareness of dementia

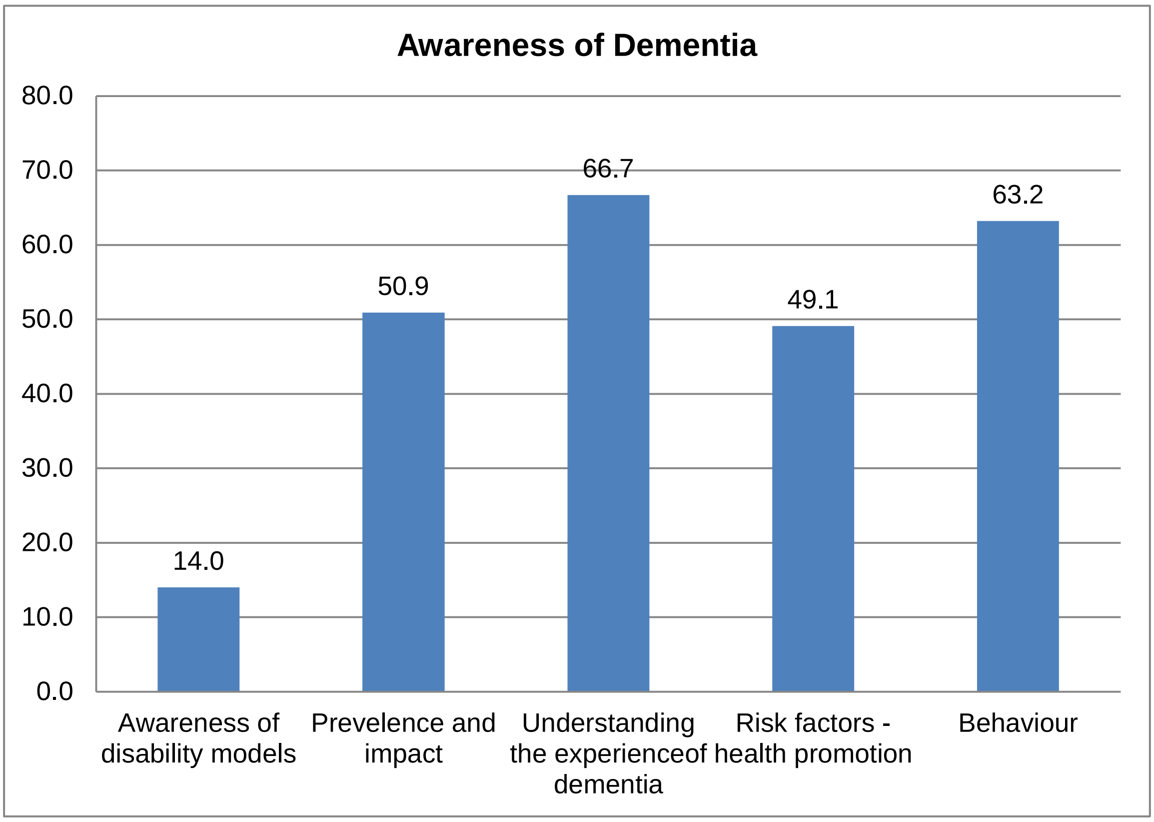


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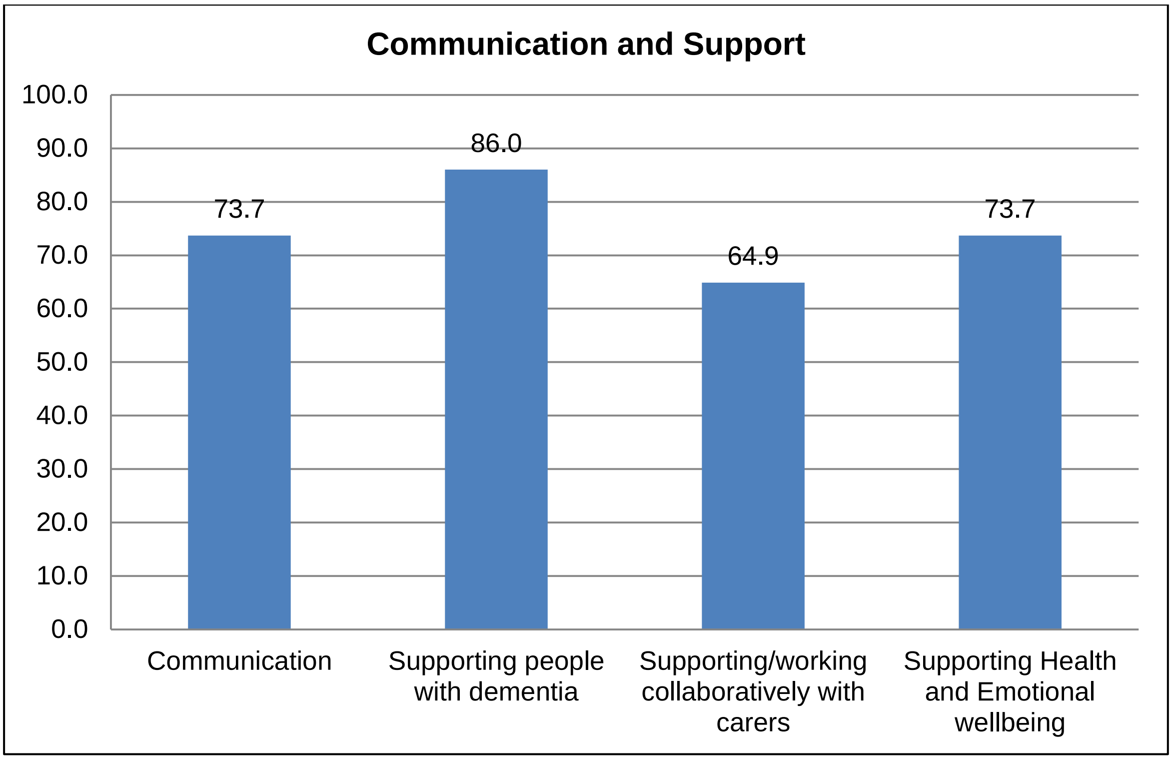
Figure 20: Training document review: communication and support



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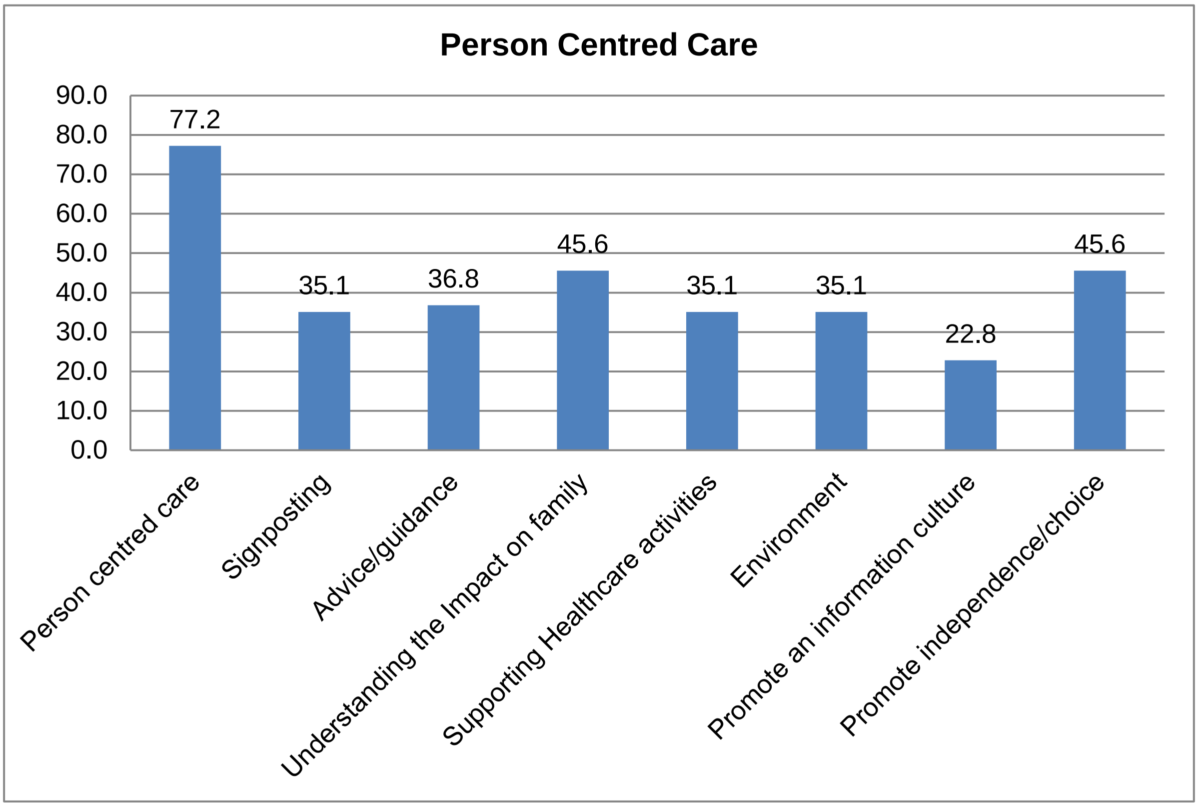
Communication and support topics were identified in over half of all the documents reviewed in this scoping phase. Over three quarters (86%) included ways to support a person with dementia, and nearly three quarters (74%) included the topics of communication and supporting health and emotional wellbeing. Supporting or working collaboratively was also identified in 65% of the documents.

A wide range of topics came under the heading of person centred care and the overall topic of person centred care itself was identified in 77% of documentation. Over two fifths (46%) of the training documents were found to discuss the impact of dementia on family members and 46% aimed to promote independence and choice for the person with dementia.

One of the topics which was difficult to identify as being delivered from the documentation, was the competency focused on promoting an information culture. It could be argued that the process of undertaking the training is promotion of an information culture, in which case 100% of courses would meet this competency. However, for the purposes of this review, this was only reported if discussion was made to sharing information amongst colleagues or creating an environment for learning. With this in mind, only 23% of training courses were identified to include the promotion of an information culture.

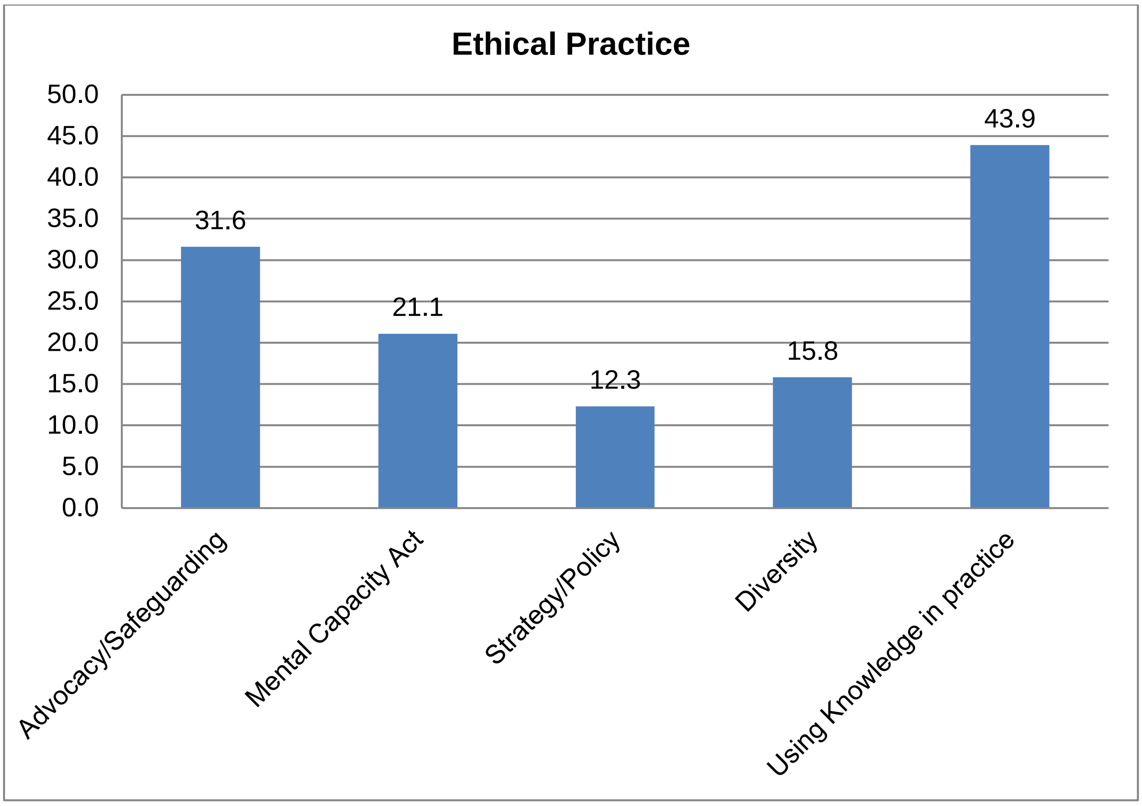
Figure 21: Training document review: person centred care



(Base: 57)

Just over two fifths (44%) of the training documents made a reference to implementing knowledge in practice, and less than a third focused on other ethical or legal matters such as advocacy or safeguarding (32%), Mental Capacity Act (21%), Diversity (16%) and Strategy or Policy (12%).

Figure 22: Training document review: ethical practice



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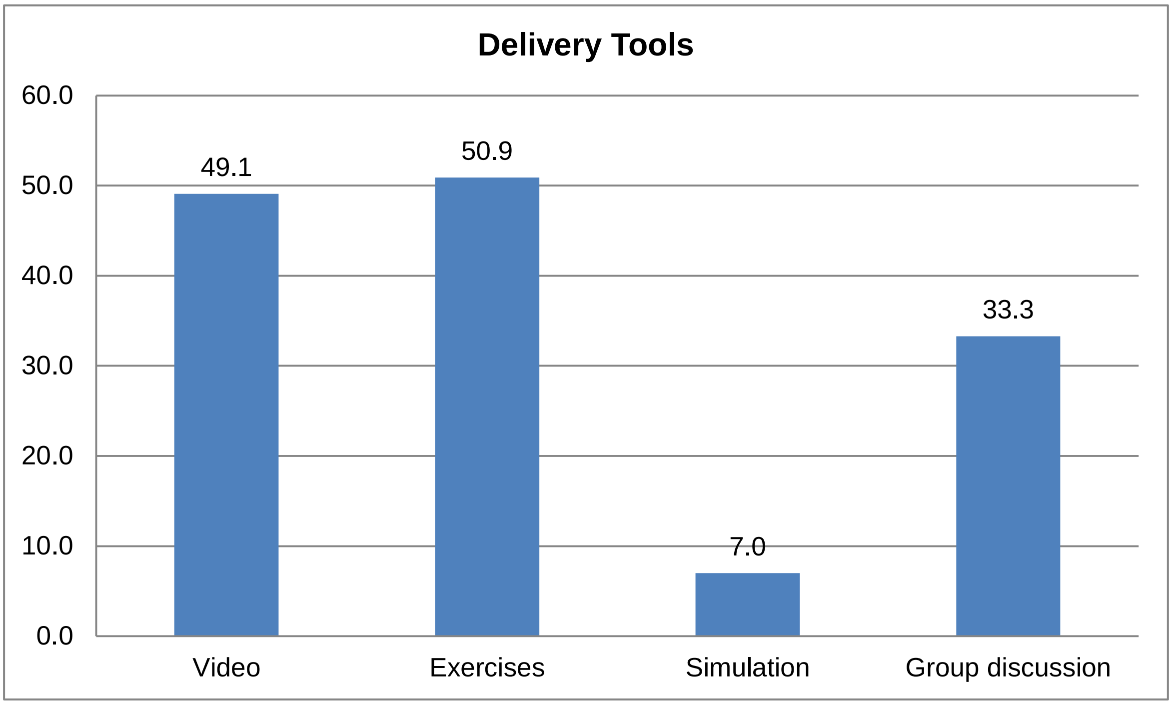
7.3 Delivery styles

One of the aspects which the team reviewed was the way training was delivered and what tools were used, for example the use of video or exercises. The length of the training courses were quite varied. Information was available for 49 of the training courses, of which 27% ran from 1-3 hours, 22% were run from 3-5 hours 31% were run from 5-7 hours and 20% lasted more than one day.

The main delivery method used by the training courses is face-to-face, which was used by 58% of training where this information was available for review. Online training is also widely available and 21% of courses were delivered online, 13% provided a mixed approach to training, using face-to-face, online, DVD, self-directed learning or handbooks. Data on delivery was available for 53 of the courses reviewed.

The use of additional tools were also widely utilised, from the documentation reviewed, half (51%) used some form or exercise to support the learning process, 49% used videos and 33% used group discussion (although it is likely that this will be higher given that at least 58% of the training had a face-to-face element). Only 7% used a form of simulation training.

Figure 23: Delivery tools



(Base: 57)

These training courses were generally open to all NHS and social care staff, however, some were only available to specific groups, for example dentists, pharmacists or care home/domiciliary care staff.

7.4 Higher level training

In identifying the Tier 1 training which has been reviewed in this report, a number of Tier 2, 3, degree level and specialist training courses were also identified. The full list of training courses is referenced in Appendix A. These training courses tended to either lead to recognised qualifications such as NVQs or degrees or develop specialist knowledge in specific areas of dementia, such as leadership, communication, dementia mapping or train the trainer courses.

7.5 Additional resources

Alongside the wealth of training courses which are available in the dementia field, from awareness training to more specialist training such as Dementia Care Mapping or SPECAL are a range of resources such as:

- Care UK, As Easy as ABC. Care UK’s Top 100 Hints and Tips for Activity Based Care.
- Care UK, Listen, Talk, Connect. Communicating with People Living with Dementia.
- Department of Health (2014) Dementia Revealed What Primary Care Needs to Know A Primer for General Practice.
- Department of Health (2010) Simple ways to Help Someone Living with Dementia.

- Guidepost Trust (2014) After Diagnosis, A Handy Guide. (available via www.dementiaweb.org.uk)
- Guidepost Trust (2014) Hints & Tips about Dementia. (available via www.dementiaweb.org.uk)
- Mental Health Foundation, The Milk’s in the Oven. A booklet about dementia for children and young people. (available at http://www.mentalhealth.org.uk/publications/the-milks-in-the-oven/)
- Royal Berkshire NHS Foundation Trust, Forget me not Information for staff about patients who may be confused or have memory problems.
- Skills for Care (2012) Dementia: workers and carers together Supporting dementia workers A guide for social care workers on supporting family and friends carers of people with dementia.
- Skills for Care (2012) Dementia and carers: workers’ resource - Information for care workers supporting the family and friends of people with dementia.
- Skills for Care (2014) Better domiciliary care for people with dementia.
- South West Yorkshire Mental Health NHS Trust (2008) The Dementia Toolkit 2008 for South West Yorkshire Mental Health NHS Trust staff.
- Worcester University, Nursing and Health Dementia Care Survival Guide.

This is not an exhaustive list of resources, nor have these been reviewed to identify best practice, it is a guide to evidence the range of resources available. This does not include the many books and DVD resources which are also available.

8 Focus groups with carers

This section reports on the emerging themes from the two carer focus groups. The focus on these discussions was on carer's access to training and knowledge on dementia and their experiences of health care. In the following discussion a number of examples of care, both positive and negative, are discussed which provide examples of case studies which could be used in training and identify the way training and practice may require a greater synergy.

8.1 Summary of discussion

Discussions focused on individual's experiences of having cared for or caring for a family member/partner with dementia, what information would have supported them better in their carer role, training which would support formal carers and health professionals to improve their dementia awareness and care and also the provision of support mechanisms within the community.

Most of the carer's in the focus groups have been looking after their partners and one for a parent. Some had cared for their person with dementia at home during the whole period, some had accessed respite or went to a care home regularly or permanently. All those that they cared for had dementia for a number of years and the care periods range from 3-25 years. Some had only lost their relatives a few months ago and others several years ago. The types of dementia that were mentioned were vascular dementia, Parkinson's, Alzheimer and Lewy Body dementia. The recollections of how and when the dementia first started was difficult for some to recall due to the length of time since the first signs and symptoms appeared.

Three overall themes were identified from the discussions:

- The experiences of caring for a person with dementia;
- To care is an on-going learning process;
- Advice gained from caring.

8.2 Experience of caring

A number of different sub themes emerged when looking at the experiences of caring for a person with dementia: a feeling of guilt and blame; sharing care experiences; challenging behaviour; communication challenges; knowledge is essential and flexibility and continuity.

8.2.1 A feeling of guilt and blame

It was reported by the focus group participants that guilt can be a part of caring. This guilt can have different origins. It can be about not knowing enough about the disease and not having enough time for care, resulting from other obligations such as work and looking after other family members. One participant explained how the wrong advice could lead to harming the person with dementia. This individual was told by a physiotherapist to leave their cared for person in bed following a fall:

'"Leave her on the bed for, leave her just on the bed", she was on the bed for three months and when she got off that bed her legs were in that sitting position. The physio said, “Can't do anything with her because she’s gone too far”, but it was him who told us to leave her in bed to start with…’

This example also shows the trust placed in the advice provided by professionals and how this can be followed to the detriment of the patient. This trust in professionals was also expressed by another participant who felt their treatment had been ‘terrible’, being treated with a lack of respect and compassion.

In the later stages, guilt was evident in the decision to move a cared for person to a care home:

‘There is a large element of guilt, there is, and one of the worst days of my life was taking my wife to a care home…I’ve failed and she’s failed, not failed but she’s struggling and things like that.’

In the group it was discussed that the feeling of guilt can be reduced if the person with dementia has less insight of what they are suffering from. This can make it easier to make the transition. This was discussed in relation to the resistance the person with dementia made about the move, as one participant commented, ‘She knows the difference, she knows the difference, but she would not sort of protest. So that also lessened my sort of stress, otherwise it would be a lot more’. In the later stage of the illness, one participant explained that he was still blaming himself for going on holiday when his wife was in respite and she was hospitalized because of dehydration and died eight days after he came home. Another participant shared his experience of how his wife went into a care home and ‘then in fact she was, had some infection problems and was transferred to a hospital and died within three or four weeks of that’.

While there are feelings of guilt associated with these shared stories, there is also a shared responsibility expressed that had better care been received these instances may not have occurred, this can be seen in the example of the physiotherapists advice or dehydration experienced by one participant’s wife. These exemplify the need for the on-going monitoring of patients and to ensure that communication with informal carers is maintained.

There is another issue raised here, that end of life care planning is an important part of dementia care and is something that informal carers and health and care services should be addressing to ensure that the final days of a person’s life are met with dignity and best practice care.

8.2.2 Sharing carer experiences

The participants in both focus groups talked about the developing relationships and support they had been able to give/receive from other carers. The members from one of the groups knew each other very well and they found that friendships had formed as a result of attending carer groups, which had been very helpful and led to shared experiences and mutual support.

But despite this shared experience and the new friendships, the experience of isolation was shared across both groups. They felt isolated with the progression of the dementia and when their partner died. There was a strong feeling that the wider community do not understand dementia and are frightened of doing something wrong or saying the wrong thing, both while the person with dementia is alive and after their death.

‘It’s the same when your partner dies, nobody comes, nobody speaks to you because they don't know what to say.’

One of the benefits of the shared experience was the shared knowledge of dementia. Carers were able to share experiences and knowledge and were able to laugh and cry about their situations without judgement.

8.2.3 Challenging behaviour

Many of the participants described how they had suspicions that something was wrong prior to the diagnosis of dementia because their partner or parent suddenly changed behaviour and could no longer managed certain things, such as play cards, playing golf or finding their way back home from town. Though it was difficult to be sure of the time when the dementia became a part of life because they did not know all the signs at that point. As the disease progressed, participants discussed how their cared for person began to forget and lose their understanding of everyday activities, for example how to knit, read and watch television. This was thought to be a gradual progression and as one participant explained, ‘They tend to forget everything in the end I think’.

More challenging behaviour was also discussed, with some experiencing their cared for person swearing, becoming aggressive, restless or engaging in dangerous behaviour, such as wandering in the street.

‘He got out once onto the main road and then he would put things on the cooker.’

One participant also explained how his wife thought that he was invading her privacy when helping her in the toilet:

‘Yeah, she thought I shouldn't be in there ‘cause I washed her and all that and she thought I was invading her privacy…’

This can be a challenge for both the carer and person with dementia and some of the strategies which were discussed to cope with such behaviours were often quite creative. For example one participant talked about taking his wife for a trip in the car when she said that she wanted to go home, and was actually at home. This act of going out in the car and returning home was a way to calm her and make her feel as though she was returning home.

This challenging behaviour was also discussed in relation to formal carer strategies, which could support both the carer and person with dementia. One participant shared a story of two carers helping his wife to brush her teeth. His wife had not spat out the toothpaste and did not know what to do, despite being asked by one carer and her husband it was only the simple action of the second carer holding out her cupped hands to the wife which helped her to understand what was required. These two examples show how a challenging situation can be mitigated through creative strategies and by using verbal and non-verbal communication, examples which show positive, person centred care approaches which could be valuable tips in a training situation.

In the later stages of the disease, the loss of recognition of family members was a cause for sadness and hurt. As one carer explained, ‘she come to me and she said, “Where’s [Bob], where’s [Bob]?” She didn't know me’.

8.2.4 Communication challenges

In different ways communication can be challenging. In the beginning it can be difficult to communicate about the disease with friends and family but also between spouses. One participant shared his experience of how both his wife and he tried to hide the early signs of dementia, prior to diagnosis, or talked with other people, ‘…I found out later that some of the things she would discuss with her friends, she wouldn’t have discussed with me and there were networks of things going on and I wasn’t fully aware of the depth of the struggle that she was doing’. Another participant shared that he did not tell his wife the exact diagnosis, ‘I felt that there was a terminal thing there and I don't know that she fully understand what that meant, I didn’t think she was going to be able to cope with it, I wasn’t too sure’. Another problem can be when the partner has difficulties in accepting their spouse has dementia, one participant shared the experience that her mother struggled with the husband’s change of behaviour, ‘my mother couldn’t accept the diagnosis; really, she couldn’t understand why he was doing all these things, so that was really difficult’.

The communication with friends also became challenging for some of the participants, because friends found it difficult to talk to or look at the person with dementia. One participant explained how their friends would come to visit but would not look at the husband with dementia. In the end the lady put a chair in a position which meant that visitors had to look at her husband but this resulted in friends ceasing to visit.

> ‘But when they did come, they wouldn't talk to [Bill], they would be talking to me, they wouldn't even look at [Bill] when there was a chair there and they wouldn't even look at [Bill] and I mean that annoyed me so I used to put the chair up by [Bill] so’s that they’d got to look that way if they was talking to me but then they got so’s they didn't come.’

However, this individual also explained that not all her friends stopped visiting but that one friend came and read the paper for the husband. She concluded by saying that ‘it’s just the opposite so some people can accept it and some can’t’. Support is therefore needed not only for the person living with dementia and their carer but also for their wider circle of family and friends to help support them and develop their knowledge of dementia.

Communication problems were also experienced with health care professionals. One participant explained the poor communication they had been exposed to by a health professional when getting the diagnosis for her father. The professional said, “Well, it’s obvious he’s got dementia… she said to him, ‘I’m going to take your car keys off you now,” and that was awful, that was terrible… Yeah, and he, up until that time he hadn’t said anything, he must have suspected and this is why I feel, he felt that he couldn’t tell anybody about his condition, you know, that’s really such a shame’. The father in this example had suspected there may be an issue but did not want to talk about it because he was worried what the outcome would be and in this case, the loss of independence by handing over his car keys had a huge impact and one which he suspected may happen, ‘And he said to me, “I knew she’d do that,”’. This expectation of poor treatment meant that communicating any concerns about the signs and symptoms of dementia was not forthcoming and the experience bore out the expectation.

The participants also discussed the way health professionals do not talk to or look the person with dementia in the eye. The perception of this approach was to reduce the time talking with patients and getting responses quicker through the carer:

> ‘...they’d take the easy way out wouldn't they to get the answer they wanted to the questions? Cut the time down at the interview because they could get the answers quicker...’

This participant also explained the way some doctors, nurses and people who came to their house would not look at his wife but him and talk with him. This made his wife ask several times:

> ‘“Aren't you going to include me in it?” She had enough sense to know she wasn't being asked or looked at.’

Another participant shared a story of informing a dentist of her husband´s dementia and the consequence of that was:

> ‘“Well, I can't, it’s no good talking to you,” to [Bill], ‘cause he said, “you can't answer me anyhow, I’ll talk to your wife,” so he talked to me sitting there.’

While in most cases the carers wanted their cared for person to be included in the conversation about their health, sometimes it is also beneficial for the carer to be the main focus of the conversation, as one participant explained, he asked the doctor to speak with him because his wife would forget what she was told. This suggests that health care professionals may need to consider the individual differences and not assume that people with dementia should or should not be involved in their care. From these examples there is a perception that while communication techniques may be the focus of much training in dementia, there may be a loss of translation from training room to practice and that this may need to be a focus for future training.

Communication techniques were thought to be an important part of dementia awareness training, and as discussed, communication in terms of verbal and non-verbal techniques, but also in terms of empathy and understanding the situation from the person with dementia's perspective.

'Communication is not just words or empathy; it is also to understand elements of communication. It is complex and the training and the awareness at these levels, when they see somebody or somebody saying something.'

This was explained in the use of tone of the voice as a person with dementia may not remember the words or full meaning of the words but the tone can be picked up.

In the later stages of dementia, communication often becomes very difficult, particularly when carers are communicating with hospitals and services, for example regarding nutrition and eating. One participant explained how her husband could not speak or feed himself and that the nurse was unaware of this, 'well, I was there till eight o'clock at night, nobody wrote anything on the board so I wrote it on before I come home. Because I mean it was no good people going and saying, "What do you want?" or leaving the menu with him 'cause he couldn't do anything... I'm not criticising the hospitals but I do think that nurses need to be aware of people with dementia'.

Another participant explains how communication can be difficult with new carers, who do not know how to communicate with the person with dementia:

'I think she got a bit anxious so she was saying, you know, "Don't swallow it," (laughs), you know, now that is the last thing you should say, because very often, the person with dementia might hear only the last part, … now she didn't know, the carer didn't know. Now, in the fact that you don't use a negative, it's communication now, but not, because she didn't, she was not trained enough.'

The perception here was that the carer had not been properly trained to deal with the situation presented and this resulted in frustration and confusion for the person with dementia and lack of confidence from the informal carer. The worry in such instances is that a lack of clear communication can lead to frustration and subsequently result in challenging behaviour developing.

8.2.5 Knowledge is essential

A common theme discussed across both focus groups was the perceived lack of dementia knowledge by the professionals, in general and also with regard to individuals. One participant was exasperated by letters he had received to take his wife for an eye test in an 'eye testing caravan', despite explaining that she was in a wheelchair and would therefore not be able to access the building, he continued to receive the letters:

'Yeah, and I got on the telephone, "I can't bring her because she's stuck in a wheelchair." "Oh, I'm sorry." And two or three weeks later I'd get another letter, "We invite you to bring your wife to the..."'

Another example shared by one of the participants, was the perception that care home staff are not always trained to a standard that is expected, particularly, in this example, young staff:

> '… and there were young people looking after him who did their best but they hadn't had enough training and I think a lot of the care home nurse, well care home staff, are people that have come, that have got to find jobs, they're young people… and they haven't had enough training and it's really difficult, when, if you're young and you're just thrown into that situation.'

In the latest stage of the disease, one participant shared an experience of his wife being fed intravenously so she had nothing passing through her mouth and this led to her not being able to swallow. This had led to distress for both the wife and her carer husband. The perception from this participant was that the training in dementia was not sufficient, as he said, what 'bothered me most of all is the fact that doctors and nurses are not trained in dementia care'.

Some of the carers had cared for their person with dementia a number of years ago and felt that the situation may have changed. As one participant explained, '…because in the early 2000 people were not aware of their dementia and also GPs were reluctant to identify, because the attitude was, or rather the view was that because of the dementia there is no medicine, so why not, why put the patient and the carers in a stressful situation, but we, ourselves was, looking for what was the diagnosis, then how do we proceed from there?'. This led the individual to seek out information from other sources to deal with the diagnosis and develop their own knowledge.

Alongside the discussions about the need for health professionals to have a good knowledge of issues in dementia, both focus groups also discussed the positive impact of formal carers having a good knowledge about dementia. As one individual said, 'I don't know where they'd been trained or how they got their knowledge, but both were very good in coping with my wife'. While another said, 'my carers, I couldn't have managed without the carers night and morning... I, well I couldn't possibly have managed without it, without them, two came every day to get him up and put him to bed and I managed the rest of the time all right'. In discussing the positive support received from the formal carers, participants also commented on the importance of communication with the person with dementia. One participant talked about her husband, saying 'he could smile, you know, had a smile on his face. And when he used to see them [carers] in the morning, she used to come in and she'd say, "Hello smiler," you know, sort of thing … she was really marvellous'. This interaction with the participant's husband clearly had a positive and lasting impact and she continued to share this positive experience, describing the way this carer had helped her husband out of bed and 'she'd dance him into the bathroom, so lovely, she was lovely'.

Positive care was also experienced by another participant, who explained the process one care home took in dealing with a compliant. A staff member had been observed to have pushed this participant's wife and the home called to explain the situation and give assurances that the staff member would no longer be in their employ. This participant felt assured that the agency had good standards of care, 'I think they had certain standards and the staff, because it was divided into two parts, a safe part and a normal, and the safe part where the people with severe dementia, where my wife was, and they were all very good, you know, and I would go in and chat to them and exchange information'. This participant felt assured by the reaction of the care home and also their knowledge of processes in dealing positively when an issue arose.

One participant also discussed the impact of certain individuals and how their knowledge can transfer to other team members. In this instance a care agency employed a particularly knowledgeable manager and there was a feeling that '… the carers who came were better trained, because she was there'. The importance of knowledge across the team and the influence of shared knowledge is highlighted in this example.

The support from the local doctor was also discussed by one participant, who had a positive experience due to their GP's interest in how the carer is managing and takes action as a result of the carer´s concern:

> 'She said to me, "What's your, have you any concerns?" I said, "Yes, my wife," and, "Why?" I said, "Well, her memory is not so good, and various other things." "Well, next time you come in, for your routine, I've made a note and we'll persuade her to go to the memory clinic."'

This support led to the diagnosis of the wife's dementia and the family being able to provide appropriate care and support.

While there were some positive examples of GPs being very helpful, there was also a shared perception and expectation that not every doctor or nurse will have an adequate knowledge of dementia. As one participant explained, 'he was very good, but GPs also have a limited experience base'.

8.2.6 Flexibility, continuity and professionalism

The group discussed a number of issues which had arisen from accessing service; these tended to be about the flexibility, continuity of care and the professionalism of services. A story shared by one participant tells of the difficulties experienced with accessing respite care and that due to the cares not attending one morning to support this person get his wife out of bed, he was unable to take the wife to the respite. This resulted in the loss of his place:

> '… and then the people at the respite say, "Where the bloody hell have you been? You've got a place here, if you're not going to use it we'll get somebody else to fill it.'

Another example given was of carers arriving earlier than had been agreed and that this resulted in a loss of the service that day. One Christmas evening, it was explained, that the formal carers had arrived earlier than agreed and the family were not home at that time. When the expected time arrived and the carers did not arrive, this participant telephoned the care office and was told ‘Oh we can't come back to you because you should have been there... And I said, “I was here five minutes after they came an hour early,” but it didn't make any difference, nobody came...’. These examples show the negative impact that a change in agreements and a lack of communication of these issues can have on the person with dementia and the informal carer.

There was also a discussion that services do not necessarily share information and that they should be talking to each other more. Another critique is that service continuity is missing. One participant talked about the number of different carers who had taken care of his wife, ‘now, during that four year period, I have got a note of it somewhere and we had, I had about 60 personal carers, OK. Now, who had come in and gone, now that means so many different persons and the person with dementia, you know, so the very fact that that is part of the discontinuity in any case. Now so long as I was there, I was retired and I’m there, I’m providing the continuity, but if there was nobody there, and you’re having 60 carers, that is concern’. This raises a concern that even if these 60 carers had been trained in the highest standards of dementia care, they still would have been a cause of concern and worry for the person with dementia because of the number of new faces and the lack of consistency of care.

There was also a concern that there are not enough staff in care homes to provide adequate care. One participant talked about a family member who is currently living in a care home and shared her concerns on this issue. This was particularly discussed in relation to financial implications that there is not enough money to staff care homes properly:

> ‘My aunt is currently suffering with dementia in a care home and it’s, you know, it’s not, there’s just not enough staff there I’m afraid. It’s all down to cost isn’t it?’

One of the key issues raised was the difference experienced in terms of care and access to information across the country. The range and consistency of services which carers could access was therefore a concern. One suggestion made, which was thought to improve the services and ensure a consistent approach was to have a dementia consultant, a dementia nurse or a counsellor that could provide a psychotherapeutic approach for the person with dementia. Additionally, it was suggested that a one stop shop would be useful, who could signpost to appropriate services and act as a liaison.

With regard to the flexibility of services, the issue was discussed in relation to meeting individual needs and how services are often not set up for this. An example was given of one family member who wanted to be able to walk. In one care setting the corridors had been circular and this enabled the individual to wander safely. However, when this person was moved to a new care home, the environment was not flexible enough to allow this and as such resulted in a negative situation.

‘He did suffer that he needed to walk about and he wasn’t able to. When he had respite in the, when we were allowed respite, it was much better, he went to a purpose built mental hospital where there was, the wards were circular, with their rooms off, and he could walk round, and there was no worry about him going into the rooms. When he came to the care home, you know, he was, the gates were sort of shut if you see what I mean. I can understand where they were coming from but, you know, it’s a bit upsetting really sometimes.’

8.3 Care as an on-gong learning process

8.3.1 To be qualified by experience

A theme from the focus groups was the idea that carers are qualified by experience and that they had developed their knowledge of dementia, and supporting activities of daily living from experience. One participant explained how he had to learn to cook, wash and clean which was a steep learning curve. This learning process was described as a minefield, ‘so I had two glorious years of looking after [Angie] (laughs) and finding my way through the minefield which was quite an experience’. It is a learning process where the participants talked about learning alongside the progression of the dementia, learning about the challenging behaviour, changing nature of dementia and trying to understand what was happing. It is about learning the negative and positive triggers and learning about themselves within the situation. One individual was surprised by this learning process, being a health professional they thought they would have insider knowledge, but this was not the case and they felt lost:

‘I thought I would know the system, but I was lost, I was lost as anybody else.’

The most important part of developing knowledge and experience was through the development of networks of support. There was an understanding that as a carer, you cannot do everything yourself. The group discussed the range of people a carer would need to collaborate with, for example a community psychiatric nurse, occupational therapist, GP, psychiatric consultant and formal carers.

The different ways to learn about dementia were also discussed. Soon after the diagnosis of his wife, one participant explained, he went to a carer course - a Carer Information and Support Programme. This course had been useful to attend and provided structured information sessions on different aspects of dementia and provided the opportunity to ask questions and exchange views. At the time of the training some of the topics had not necessarily been fully understood or appreciated, but as the dementia progressed the knowledge of these topics became important. As this participant explained:

‘I found certain things useful, some things I didn’t think would ever happen to me but of course eventually they did and I was pleased to have heard about them…’

Other participants discussed attending Alzheimer’s Society cafes where speakers come and talk about dementia.

Most of those attending the focus groups explained that they had not known anything about the disease before receiving a diagnosis, as one person explained, ‘nothing at all. We knew that people, you know, lost their memory and things like that but you didn't, the one thing we didn't know, there was a difference between Alzheimer's and Lewy Body’s and all those, we didn't know that’. Participants were asked if they had received any information from GPs or other services, the answer tended to be no and that their knowledge had developed through experience:

‘No, we picked it up on the way.’

The Alzheimer Society was mentioned as being particularly useful and providing some good resources:

‘I did find the Alzheimer’s Society helpful but I dropped in and dropped out of them and asked for advice for specific things and they gave me advice...’

It should be noted that often charities, such as the Alzheimer’s Society are signposted by the health care services (GPs etc.) to support and provide information to carers rather than provide this individually by each service. This may be an area which requires greater promotion so that people being diagnosed with dementia are properly signposted and understand where and why certain services are able to provide this support.

One participant explained that he and his sons had looked through the literature themselves. Another participant discussed the experience they had of the changes in behaviour and physical ability and when asking the professionals for explanations of this behaviour, they were told:

‘“Oh, didn't we tell you that?” (laughs) “Yeah, this is a symptom, this is another symptom.” (laughs)’

The feeling was that these issues should have been explained and discussed but that in reality the information was provided retrospectively and only when the right question was asked.

The discussions also led to describing learning about dementia as not only a medical problem but also ‘a social problem, a care problem, a support problem’. The feeling from the groups was that more information was needed on the way dementia can progress and how best to ‘manage somebody’ through that progression. Additionally, information about legal issues, lasting power of attorney, mood change or managing wandering behaviour would also be helpful for cares.

8.3.2 Difficulties in getting help

One of the emerging themes from the focus groups was the feeling that it can be difficult to find out where to get the correct help and services. One participant commented that ‘you have to go and fetch and borrow and moan and groan until you get the information you want or find the right person. And you can do it but good God does it take you a long time...’. Often, it is more difficult than had been anticipated:

‘There’s no perfect, swift, easy channel obviously. Didn't expect it because it came out the blue so nothing was going to be easy, you knew that, you realised that but when you wanted the help you could never find the blighter you wanted, you know, (laughs) .’

There was a sense that the situation was trial and error without any formal help. As one participant commented, ‘we weren’t given any help really; it was just trial and error, learning’. Knowledge came from the inevitable mistakes made in caring for someone with dementia and that this learning process was constant.

‘There’s an awful lot of mistakes we’ve made, no two ways about it. It has been a big learning curve the all way and all the time. Oh good lord, if we only knew now, it, you know...You could walk through anything.’

The members of the focus group thought that the information was available, but too often it depended on asking the right question. As one carer said, ‘... You're not going to get it because nobody advises you, nobody advises you at all...’. It can be difficult to know where to go to and who to go to, and even when getting in touch with services they were not always able to help or provide the support needed:

‘… they did send us some leaflets, told us to get in touch with social services, which we did, but that was not really very helpful, although we did get some care later on, you know, half an hour to sort of shower him, things like that. I’ve got a sister, so between the three of us we sort of managed really, until my mother had a heart attack, and then he had to go into a care home, so, yeah.’

The timeframe to receiving assistance was also discussed, as one participant commented, ‘you’ve got to wait three or four months before you could get hold of it and of course by that time the patient was really worse off. I mean it took me nine months to get my bathroom sorted out’. Issues were also experienced in accessing benefits, again this was discussed in one of the groups as something they found out themselves, through talking with other carers and was not discussed with any of the support services. As one participant explained, ‘I think that’s the thing that we didn't, none of us knew...’, and as another explained, ‘the governmental departments don't tell you anything, nothing at all. You just have to find out from other people’.

The discussions also led to finding care homes, nursing homes or respite care, which was described as ‘traumatic’ due to the lack of help and support experienced. One participant described the decision to move to a nursing home had been difficult and finding a suitable one was just as hard. Depending on the needs of the person with dementia, access to care homes could be complex. One participant explained that the need for one to one care had resulted in his wife not being ‘accepted’ by some services, while another participant described the use of a hoist to clean her husband meant ‘they didn't want to know that, it was too much trouble for them... they were not fully staffed’. As previously discussed, the perception here was that staffing levels in care homes had an impact on the care being provided. Another problem discussed was the difficulty of choosing a care home at short notice, for example after a stay in hospital, there was a feeling that the choices were limited in such a case.

‘Because you had to know the time, the hospital was just wants to, out… They can’t actually go home because their care [inaudible] package won’t do it, so you know, we’re stuffed, you know, in terms of what you can receive.’

‘There was a sense that often you had to ‘fight’ for services and that this could make ‘… you hard, make it ever so hard to make sure you get the best what you want or what you can get...for the person you're caring for...’

8.3.3 The need of protection

The carers attending the focus groups talked about the need to protect the person with dementia. One participant explained how he tried to support his wife in social situations, making sure that visitors were aware of how best to support her, for example by limiting the number of people who visited at any one time:

‘Fine, come along, but I would rather than just one or two of you came at a time, rather than more.’

Another participant explained that she woke up in the mornings before the carers came and massaged her partner´s legs, did his exercises and got him ready for the carers’ arrival, the reason for this was ‘…because I couldn't, I know that he wouldn't have wanted to be laying in bed and I don't think I could have coped with him laying in bed’. In this instance there was a desire to support her husband but also her own needs and feelings of dignity.

The need of protection was also expressed by the person with dementia. A story was shared of a participant’s wife, who had been diagnosed with dementia, wanting to be close to her family to ensure she would be fully supported in case something happened to her husband, her primary carer.

‘My wife and I actually moved in 2009 to be nearer two of our sons because my wife was becoming concerned that if anything happened to me, what would she do? Let us move near our sons.’

This protection was also discussed in relation to ensuring carers coming into the home provided the best service and when this was not achieved some of the participants described the action they took in changing the carers. This meant contacting the care agencies, and requesting a change of staff to ensure they had the appropriate knowledge and experience. An example of this was provided by one participant who shared and experience where two carers had been washing and dressing his wife in the morning as though she was nothing more than a ‘lump of meat’:

‘They were just shouting at each other over the top and they treated her like she was a lump of meat, she could have been on a butchers slab for all that they cared and I didn't think a lot to that so I told them I didn't want them coming again, treating my wife as they treated her.’

One of the groups considered what would happen for those who were living alone with dementia and how they were being supported:

‘It makes one thinking what about what people do not who has anybody.’

8.4 Advice gained from caring

8.4.1 Using carers’ knowledge

The knowledge gained from being a carer was thought to be valuable, particularly in terms of sharing that knowledge. The inference was that cares had a ‘job to do’, particularly in sharing the knowledge with health professionals.

‘So carers like us would have a job to do (laughs) to make people aware of it...Because my local doctor hadn't got a clue...’

There was a perception that health professionals do not always have a depth of knowledge or understanding of dementia and that they could be ‘frightened to do the wrong thing’, therefore sharing that knowledge was thought to be an important role for experienced carers.

The role of the carer to raise awareness more generally in society was also important, as one participant commented, they wanted to contribute their knowledge and experience to get more awareness in society as they felt guilty they had not known enough through their own carer experience:

’I still feel very guilty about my father, that I didn’t know enough about the disease, or we didn’t know enough about the disease so that’s basically why I am here, because I really feel passionate about raising awareness.’

8.4.2 Include the person with dementia

In the focus group the discussion turned to how important it was to include the person with dementia in conversations and activities. For example participating in activities such as card-making, jewellery-making - even if the person with dementia was not able to fully participate in the activity. This engagement in an activity was thought to be much more beneficial to sitting in a chair and doing nothing but watching television.

‘[Bill] couldn't take part in the card-making or the jewellery-making ‘cause he couldn't do that but he could sit at the table and watch the others doing it which he enjoyed doing that.’

This activity, at whatever level of participation, was thought to be positive, in giving people ‘something to do…’. Remembering that the person with dementia is still a person was important, as one participant stated, ‘…this is one of my bees in my bonnet, she’s still a person... and must be treated as an individual with their own needs as well as mine and anybody else’.

The discussion of inclusion of people with dementia was also discussed in relation to power of attorney and the associated problems. One participant described the process of gaining power of attorney and was thankful that his wife had been able to sign the relevant documentation:

‘If she hadn't have signed it when she could still sign, I couldn't have got it. They had to be able to sign to give you like permission and that, I thought that was wrong and all.’

8.4.3 Community awareness

Although the focus of the discussion centred on links with health professionals, a number of participants thought that the real problem was with the wider public, particularly people in hotels, in shops etc. One participant had experienced stigma and thought this was due to ignorance about dementia. There was a discussion about the changing understanding of dementia from the public; in the early 2000s the public assumed that people with dementia were mad, because of their behaviour, one participant described how they had worked to ‘educate or tell them that she’s not mad, it’s not like a person is mad, it is the dementia’. There was a feeling that people are becoming more aware of dementia:

‘I think that it’s much more, people are much, dementia friendly if that’s the word, or more aware aren’t they, nowadays. I mean we did take my, we used to take my father, even though, we took him to the local sort of pub which is, for his lunch sometimes and they were absolutely brilliant with him there…’

Another story was shared of when a person with dementia panicked on a shopping centre escalator and had been helped by a security man:

‘So he watched it and helped and took them away to have a coffee and settle him down. So that was an example of where someone in a store knew the problems and watched it, and helped, and I think that is where we’ve got to go and get wider information.’

The examples of positive support within the community also included a story from one carer who spoke of taking his wife everywhere, coffee shops, shops etc.

Knowledge, awareness and common sense were thought to be important, particularly awareness:

‘It only wants people to be aware of it, they don't need to do anything about it, just be aware.’

It was thought to be important that the wider community get to know about dementia and the problems that people experience and the development of the dementia friendly communities was a welcome initiative and one that was a positive start to changing community perceptions. But this was thought to require further action, for example in ensuring appropriate signage in shop/hotels etc. and in giving information to children through schools.

8.4.4 Support the carers

Ensuring cares have the appropriate support was also discussed, particularly in relation to the two way communication between NHS, professional carers and informal carers. Being able to provide clear information about how best to support the person with dementia was central in this debate:

‘You as carers getting the right information and having the right signposting, but also actually being able to give that information to the person you’re caring for as well, the person.’

The support the cares wanted was more information from professionals regarding coping strategies and communication techniques. As well as the one stop shop already discussed, it was suggested that carers could be given a carer’s pack with information about dementia, what they could expect and tips and techniques. In addition, attending a dementia friend session or information session could also be useful. The emotional, practical and financial issues were also challenging and a joined up approach to supporting these aspects would also be appreciated.

General support to rest or do practical things was also important, this was discussed by one participant who explained the value of respite:

‘… we had support from Age Concern and my wife went there one day a week, which gave me a day’s rest to get the shopping and whatever.’

Not having this support could lead to negative consequences, one participant explained that his wife did not want to have carers in their house so it was left to him to look after her day and night:

‘I got in such a bad sleep pattern and I’ve still got it even two years on, it’s two years since she went, I got in a very bad sleep pattern and I don't sleep very well at night in any case now anyhow.’

The impact of poor support can have quite long term impact on the carer, as exemplified here.

8.5 Implications for training

A number of implications for training and services have been raised through the focus groups, the main issues being:

- Greater signposting to services/ One Stop support/ Carer pack on diagnosis
- Developing a network of support (formal and informal)
- Developing communication techniques – verbal and non-verbal
- Developing person centred care – learning about the individual and building rapport/empathy
- Training for friends and family
- Consistency of training/knowledge and standards across services – What are the required standards?

What also came out of the discussions was the need not only for training for health care staff but also that the management of services need to be able to support the care of people with dementia. Examples were given of multiple care staff coming into the home, providing varied care and confusion for the person with dementia. Ensuring that staff have time to build a rapport with the person they care for and are not just there to provide care but understand how best to provide that care was an important theme emerging from the group.

9 Online staff survey

An online survey was developed to gain the wider views of staff across a range of organisations, primarily in health, to gain their views on dementia training, what they may have accessed and what would be valuable to support them in their roles. Complete responses were received from 74 participants. The following presents the key findings from this survey. Percentages are presented from those who responded to the question.

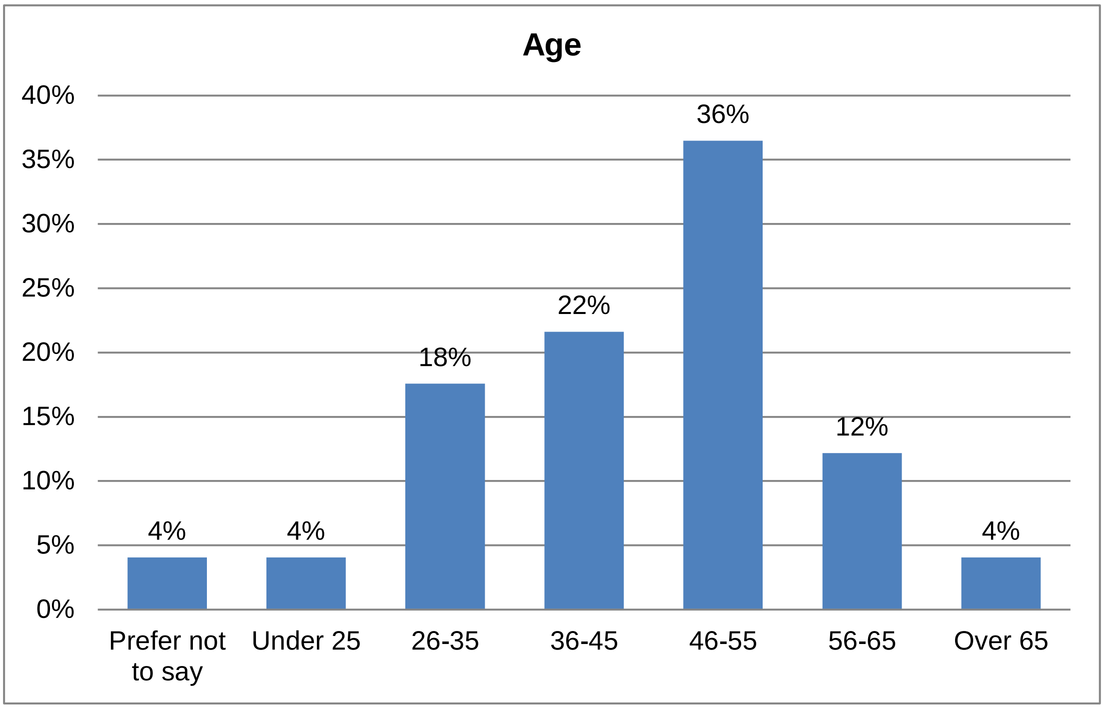
9.1 Respondent demographics

Of the 74 participants who responded, 20% were male and 80% were female. Respondents ranged in age from 19-69 years, with over half (58%) aged between 36-55 years, and the majority of respondents came from Reading (18%), West Berkshire (16%) and Oxford (16%) (Table 3).

Table 3: Geographical location

Area	**No**	**%**
Reading	13	17.6
West Berkshire	12	16.2
Oxford	12	16.2
West Oxfordshire	6	8.1
South Oxfordshire and the Vale of White Horse	5	6.8
Windsor and Maidenhead	5	6.8
Wokingham	5	6.8
Other	4	5.4
Slough	4	5.4
Milton Keynes	3	4.1
Cherwell	2	2.7
Aylesbury Vale	1	1.4
Bracknell Forest	1	1.4
Chiltern	1	1.4
Total	74	100

Figure 24: Participant age range



(Base: 74)

Participants were also asked which sector they worked in. Over half (57%) of those responding worked for the Health sector (see Table 4 for full responses). Those working in the health sector came from a variety of roles, including:

- Community staff nurses (n=4);
- Occupational Therapist (n=4);
- District nurses (n=3);
- Doctor (n=3);
- Staff Nurse (n=2);
- Allied Health Professional (n=1);
- Assistant Psychologist (n=1);
- Community Dentist (n=1);
- Community Matron (n=1);
- Lead nurse (n=1);
- Manager - Health & Wellbeing Centre (n=1);
- Matron (n=1);
- Memory Clinic Nurse (n=1);
- Mental Health Act Manager (n=1);
- Nursing (n=1);
- Pharmacist (n=1);
- Physiotherapy Assistant (n=1)
- Podiatry Hygienist (n=1);
- Practice Educator (n=1);
- Practice Manager (n=1);
- Psychological therapist (n=1);
- Registered Community Nurse (n=1);

- Registered Mental Health Nurse (n=1);
- Senior Dental Officer (n=1);
- Superintendent Pharmacist (n=1);
- Therapist (n=1);
- Project Lead - Dementia Learning and Development (n=1).

Of those responding, over two thirds (67%) were in full time employment and a further 30% were in part time employment (see Table 5).

Table 4: Sector

Sector	**No**	**%**
Health	41	56.9
Charity	8	11.1
Business	6	8.3
Local Authority	6	8.3
Public Sector	5	6.9
Social Care	3	4.2
Education	2	2.8
Other	1	1.4
Total	72	100.0

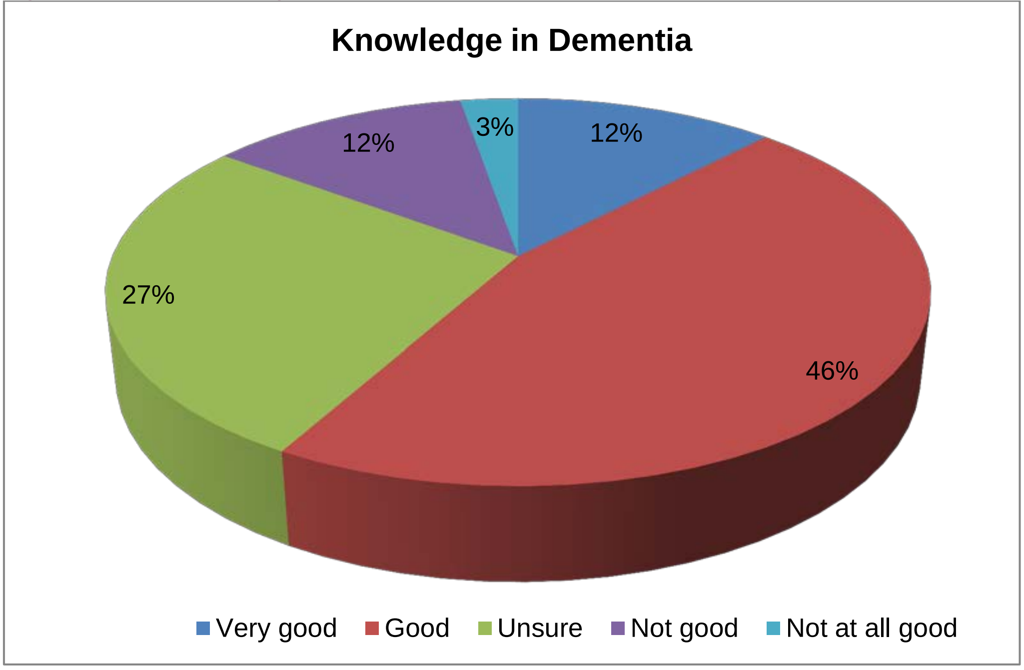
Table 5: Employment

Employment	**No**	**%**
Working full time	50	67.6
Working part time	22	29.7
Studying at School/College/University	1	1.4
Other	1	1.4
Total	74	100.0

9.2 Dementia knowledge and training

Participants were asked to rate their knowledge and understanding of issues relation to dementia, over half (58%) rated their knowledge as very good or good, 27% were unsure and 15% rated it as not good and not very good. The full responses are presented in Figure 25. For those working in the Health sector, just over half (51%) rated their knowledge in dementia as good or very good, a further 37% were unsure.

Figure 25: Knowledge and understand of dementia



(Base: 74)

Participants were also asked whether they had accessed dementia training (where more than one course had been accessed, respondents were asked to comment on the most recently attended), 48% had accessed some form of training. For those working within the health sector, specifically, just under half (47%) reported to have accessed training on dementia. The range of training varied in terms of level of study and provider. The following is a full list of the training providers reported:

- Alzheimer's Society;
- Anchor Trust;
- BDA CDS;
- Berkshire Healthcare Foundation Trust;
- Bradford University;
- Bristol University;
- British Society of Gerontology;
- City & Guilds (OXCARE);
- College of Occupational Therapists, London;
- Department of Dementia Studies Worcester University;
- Dementia Care Mapping- Bradford university;
- Dementia Friends;
- Dementia UK;
- Derbyshire County Council;
- E-learning for health;
- Guideposts Trust;
- Hawkins;
- Home Instead Senior Care;
- Independent trainer;
- Milton Keynes Hospital;
- New Dementia Care;

- Oxford Academic Health Science Dementia Network (DEnDron);
- Oxfordshire County Council;
- Royal Berkshire NHS foundation trust;
- Royal Voluntary Service;
- University Of West London;
- YoungDementia UK.

The level and length of course varied greatly, but most had attended a form of level 1 or dementia introduction/awareness training. This included dementia champions and dementia friends training. A small number had done higher level training, reporting this as level 2, 3, 6 and 7.

As would be expected from the range of training providers accessed, the length of the coursed varied greatly. Those which were of a higher level were run over a much longer period, with some participants studying for up to two years. The majority had attended training which lasted from an hour to one or two days.

Participants reported a wide range of topics covered in the content of the training, however the core common areas were:

- Behaviour;
- Understanding dementia;
- Carers perspectives;
- Causes of dementia;
- Types of dementia;
- Treatment;
- Working effectively, practical skills and management/support (for person living with dementia and carer);
- Person centred care;
- Communication;
- Medical model.

The majority of participants (81%) had found out about this training through their work and a further 16% had heard via a dementia charity/organisation (see Table 6 for full responses). Other ways in which participants had heard about the training was through colleagues, telephone contact and on-going training.

Table 6: Course information

Course information	**No**	**%**
The internet	2	6.3
A dementia charity/organisation	5	15.6
A poster/flyer	0	0.0
Through work	26	81.3
Through a friend	1	3.1
Through family	0	0.0
Other	6	18.8

(Base: 32, multiple responses)

For over half (59%) the training had been free to attend and for 53% work had paid for the training. Only one person had paid to attend the training.

When asked whether they would recommend this training, most of those responding to this question were very positive. The different training accessed was thought to have been ‘excellent’, ‘good’ and ‘insightful’. In considering why these training courses had been reported so positively, the key features why this was the case centred on the content and learning around dementia, particularly the practical applications to work and developing people’s understanding of dementia. For example, one participant reported that the course attended had given an ‘understanding of what living with dementia type illnesses could be like’, furthermore, this had been delivered on a ‘practical level’ involving role-play.

This depth of understanding of dementia was commented by others (attending different courses) as being a positive factor:

‘The course provided very good foundational knowledge.’

‘It helps update current knowledge and future proof it.’

‘All the training I have attended has extended my knowledge and skills relating to caring for someone with dementia.’

Similarly the practical application of the knowledge to practice was appreciated by those responding to this survey. Participants’ feedback on the way skills could be implemented in practice, how best to work with people with dementia and how to improve clinical practice.

‘It focused on how to work with dementia.’

‘Relevant to better patient understanding and clinical skills.’

‘Very good insight into best practice.’

However, one participant added that these skills need to be practiced daily to make sure that the patients receive the best care.

‘The way of working needs to be used on a daily basis and observed by staff to increase their positive interaction with clients.’

The facilitator was also reported as a factor which led to positive feedback, as one participant reported: ‘excellent training with a high level of knowledge, facilitated by skilled trainers with high level of empathy and understanding of dementia’.

For those who were less positive about the training they had attended, two were run in-house and were thought to be more general awareness of dementia and two individuals reported that while the course may have been good it was difficult to implement the training into practice.

‘It was not a formal training course - just internally provided to raise awareness of dementia.’

‘But did not go into detail about how to adapt techniques and approaches to get the best out of them.’

Those responding to the survey were also asked if there was anything that the training did not cover that they would have liked or expected. Generally, most participants reported that the training had covered the areas expected but some felt that more information was required, particularly with regard tips, techniques and ways of engaging with people with dementia. Particular areas of focus were:

- Anxiety in dementia;
- Adaptation of practices for people with dementia;
- Mental capacity act/legal issues;
- Medication and their side effects;
- Physical health problems related to dementia;
- Links with learning disabilities and dementia;
- Interventions/aids for people with dementia and their effectiveness;
- Signs and symptoms;
- Causes of dementia;
- Diagnosis.

‘I would have liked more tips / ideas around coping with anxiety in dementia. Also, more basic ideas how to engage with dementia patients, how to adapt normal approaches.’

‘I would like more training on how to deal with people dementia.’

‘More in depth information regarding dementia and its causes, signs and symptoms.’

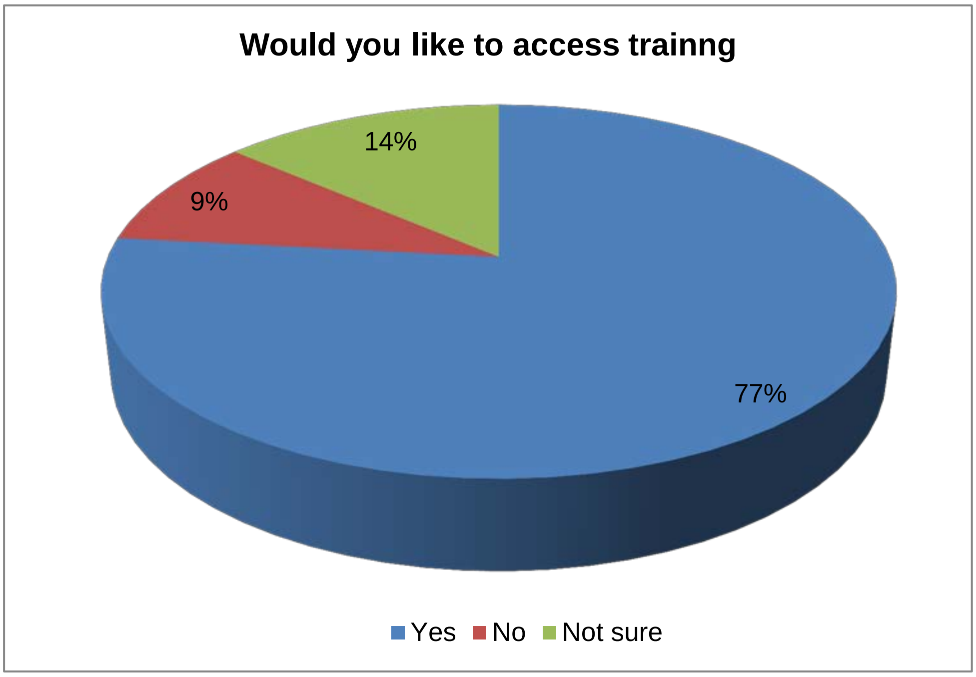
‘Probably more detail about the aids available for dementia sufferers and current research also.’

Finally, one participant requested that a ‘visit to a specialist dementia unit in acute hospital’ would be a valuable addition to training.

9.3 Future training needs

When asked if they would like to access (more) training on dementia awareness just over three quarters (77%) of participants said they would (see Figure 26 for full results). This figure is higher when looking at those within the Health sector only, with 88% reporting to want further training in dementia.

Figure 26: Would you like to access (more) dementia awareness training



(Base: 74)

When asked the reasons for wanting to attend dementia awareness training, 82% wanted to develop their knowledge/awareness of dementia, 79% wanted to learn best practice for working with people with dementia while 75% wanted to get a better understanding of how to support people with dementia and to support their interactions with people with dementia.

Only 27% reported the reason to be a result of a friend or family having a form of dementia and 16% due to expectations from work.

Table 7: Reasons for accessing training

Reason for accessing training	No	%
Develop my knowledge/awareness of dementia	58	81.7%
Learn best practice for working with people with dementia	56	78.9%
Get a better understanding of how to support people with dementia	53	74.6%
To support interactions with people with dementia	53	74.6%
To recognise and understand dementia	46	64.8%
Am interested in dementia issues	37	52.1%
Family/friend has dementia	19	26.8%
Expected to attend for my work	11	15.5%
None of the above	3	4.2%
Other	8	11.3%

(Base: 71, multiple responses)

A number of other reasons were given for wanting to access training were to improve sharing of knowledge amongst colleagues and to keep ‘up to date’ with the latest thinking and good practice on dementia care.

‘Update new ways of working and treatment. Sharing 'What works'.’

‘Meet clients daily with issues would like up to date information.’

‘Want to learn as much as possible on dementia and pass on my knowledge to carers.’

When considering which subject areas participants were most interested in, learning communication techniques (73%), supporting people with dementia and carers (69%), awareness and understanding of dementia (65%), signs and symptoms of dementia (65%), understanding different types of dementia (65%) and signposting carers/people with dementia to appropriate services (62%) were the most popular (Table 7). However, when considering those within the Health sector only (Table 8), the topic areas which were of most interest were:

- Awareness and understanding of dementia (83%);
- Understanding the different types of dementia (81%);
- Signs and symptoms of dementia (78%);
- Learning communication techniques (78%);
- Supporting people with dementia and carers (73%);
- Person centred care approaches/ethos (71%).

Table 8: Topics for future training – all respondents

Future training	**No**	**%**
Learning communication techniques	52	73.2%
Supporting people with dementia and carers	49	69.0%
Awareness and understanding of dementia	46	64.8%
Signs and symptoms of dementia	46	64.8%
Understanding the different types of dementia	46	64.8%
Signposting carers/people with dementia to appropriate services	44	62.0%
Person centred care approaches/ethos	40	56.3%
Understanding about dementia friendly communities	37	52.1%
Understand what it is like to have dementia (carer and person with dementia perspective)	36	50.7%
Policy and legislation on dementia	36	50.7%
None of the above	1	1.4%
Other	7	9.9%

(Base: 71, multiple responses)

Table 9: Topics for future training – Health sector respondents

Future training	No	%
Awareness and understanding of dementia	34	82.9%
Understanding the different types of dementia	33	80.5%
Signs and symptoms of dementia	32	78.0%
Learning communication techniques	32	78.0%
Supporting people with dementia and carers	30	73.2%
Person centred care approaches/ethos	29	70.7%
Signposting carers/people with dementia to appropriate services	28	68.3%
Policy and legislation on dementia	26	63.4%
Understand what it is like to have dementia (carer and person with dementia perspective)	24	58.5%
Understanding about dementia friendly communities	20	48.8%
Other	3	7.3%
None of the above	0	0.0%

(Base: 41, multiple responses)

The other areas which were suggested by participants were:

- Mental capacity act;
- Brain function;
- A higher knowledge of signs and symptoms;
- Stoma care for people with dementia.

Participants were asked to comment on the subject areas which would be most useful to include in dementia awareness training. A variety of responses were given, however there were three key areas which were most widely reported: how to best support a person with dementia/carer; communication techniques; understanding the signs and symptoms of dementia.

Signs and symptoms of dementia (n=13) was reported most widely by participants of this study as being most useful to support them in their role. This was discussed in relation to diagnosis and early symptoms and recognising dementia (both clinically and within the community and in relation to other disorders).

‘Distinguishing dementia from other underlying mental health issues.’

Supporting people with dementia (n=9) was also reported as most useful, particularly in gaining an understanding of the impact/benefits of the support or intervention for people with dementia and carers, helping people to live at home longer, how to support both on a 1:1 basis and also within a group, working with families and providing support networks.

‘Helping people with dementia make the transition from living at home to living in a more supportive environment.’

Similarly, communication (n=9) and being able to talk with people living with dementia and carers was thought to be most useful. One participant also suggested that understand the role carers have in supporting the communication process would also be valuable.

‘Communicating techniques would be useful as I treat patients with dementia and sometimes it can be difficult also spotting signs and symptoms would be useful.’

Other topic areas suggested were:

- Awareness and understanding (n=4)
- Comorbidities (n=3)
- Challenging behaviours (n=3) (how to calm patients, deal with distress)
- Strategies (n=3) (adapting practice)
- Signposting (n=3)
- Young onset and Learning Disability (n=3)
- Legal issues, consent, policy and legislation (n=3)
- Capacity/psychological assessment (n=2)
- Involving people with dementia (n=1)
- Side effects of medication (n=1)
- Dementia friendly communities (n=1)
- End of life care (n=1)
- Integrating learning into practice (n=1) (particularly where the environment is not dementia friendly)

‘How to adapt my normal approaches in order to engage with the patient. Many patients with dementia are very anxious and this can be a barrier. Many patients have short term memory problems which hinder rehabilitation so ideas how to overcome this would be helpful.’

‘How to integrate the practical skills learnt into an elderly rehab ward environment which is busy and not dementia friendly in design.’

‘Legal aspects. Patient consent is a concern when suggesting dental work. Relatives often don't say the person has dementia.’

‘Supporting people with dementia and picking up on cues of agitation or being upset or aggressive. Helping to reassure and gain their confidence.’

Regardless of what training covered, one participant made the valuable point that what is delivered has to lead to ‘realistic and practical skills’ development. While another requested that training recognised that not everyone engages with people with dementia and carers in a clinical setting (‘that the training acknowledged not everyone works clinically’). The format of training was also reported by one participant as key to the learning process, this individual suggested that the use of scenarios and activities let to greater effectiveness, while the ‘input from carers who can ground the theory into practice' was also helpful and 'makes the sessions come to life and the retention of key information is significantly increased'.

Following on from this, another participant commented that responding to the needs of their workforce was important and understanding their needs in terms of training was paramount. While another participant reported that staff were starting to request the need for more advanced training, moving more into the area of Tier 2 and 3 training, or developing specialist knowledge in particular areas, such as communication or interventions.

> 'But what staff are requesting is more advanced training due to the complexity of the patients.'

One participant also raised an interesting notion, that there are a number of providers running training and each has their own model of how best to care for and interact with people with dementia. This has been a key finding of this scoping phase of the project also. The key message from this participant was that they wanted to 'learn as much as possible from as wide a range as possible in order to understand and provide a better service myself'. Therefore enhanced knowledge leading to improved care is central to why training is undertaken. However, another participant wanted to know what training was available and which was best suited to different staff groups, suggesting that identifying the right training for staff could be difficult.

Finally, one participant also commented on the need for the wider services to respond to the dementia challenge, asking 'how can I make the social services understand and respond to the needs of the patient?'. This is a theme which has emerged throughout this phase of the project and one which shows the need for services to consider their approach to dementia from a more strategic level and not just on the individuals who are caring for and supporting people with dementia.

9.4 Barriers to training

Participants were asked whether any factors had an impact on their access to training. Of those responding to this question, just under a quarter (23%) reported that not knowing where to find out about training and that they had already read about dementia on the internet or in books had impacted on their access to training.

Table 10: Access to Training

Access to training	**No**	**%**
I'm not sure where to find out about training	16	23.2%
I've read about dementia through the internet/books	16	23.2%
My work does not offer training	11	15.9%
I don't see this as relevant to my work role	8	11.6%
I don't see this as relevant to my personal life	2	2.9%
I'm not interested	1	1.4%
I feel that I know enough about dementia already	1	1.4%
None of the above	17	24.6%
Other	17	24.6%

(Base: 69, multiple responses)

Access was also impeded by a number of other factors, including cost of training, the over subscription of courses, time to attend (in relation to work pressures and the pressures of attending mandatory training), knowledge of which courses are ‘good’ and worthwhile and dementia being only one area of knowledge required for work.

‘Time, and the fact that this is only one area of my work and I need to prioritise training in other clinical areas. Also haven’t really seen any training that provides significantly more detail to make it worth going.’

‘Training is offered via my trust but time/ staffing makes it difficult to attend.’

‘V[ery] little time available for training outside of the statutory and mandatory training.’

One individual suggested that training in dementia ‘… should be mandatory, since it's becoming more prevalent’.

Participants were asked more directly what barriers they faced to accessing training. Over half (59%) reported that time off work was a barrier, with just over two fifths (43%) reporting that cost of training was also a difficulty. A small number of participants reported that they did not find the issue relevant (5%) or of interest (2%). For those within the Health sector, time off work (71% of respondents) was the main barrier reported.

Table 11: Barriers to training

Barriers	**No**	**%**
Time off work	36	59.0%
Cost of training	26	42.6%
Not relevant to me	3	4.9%
Not interested	1	1.6%
Other	13	21.3%

(Base: 61, multiple responses)

Other barriers reported also related to accessibility, with childcare, training location and waiting lists for courses causing difficulties. Finding suitable training that met the needs of the individual/organisation was also reported as a barrier. A number of participants also reported that they did not feel there were any barriers to accessing training.

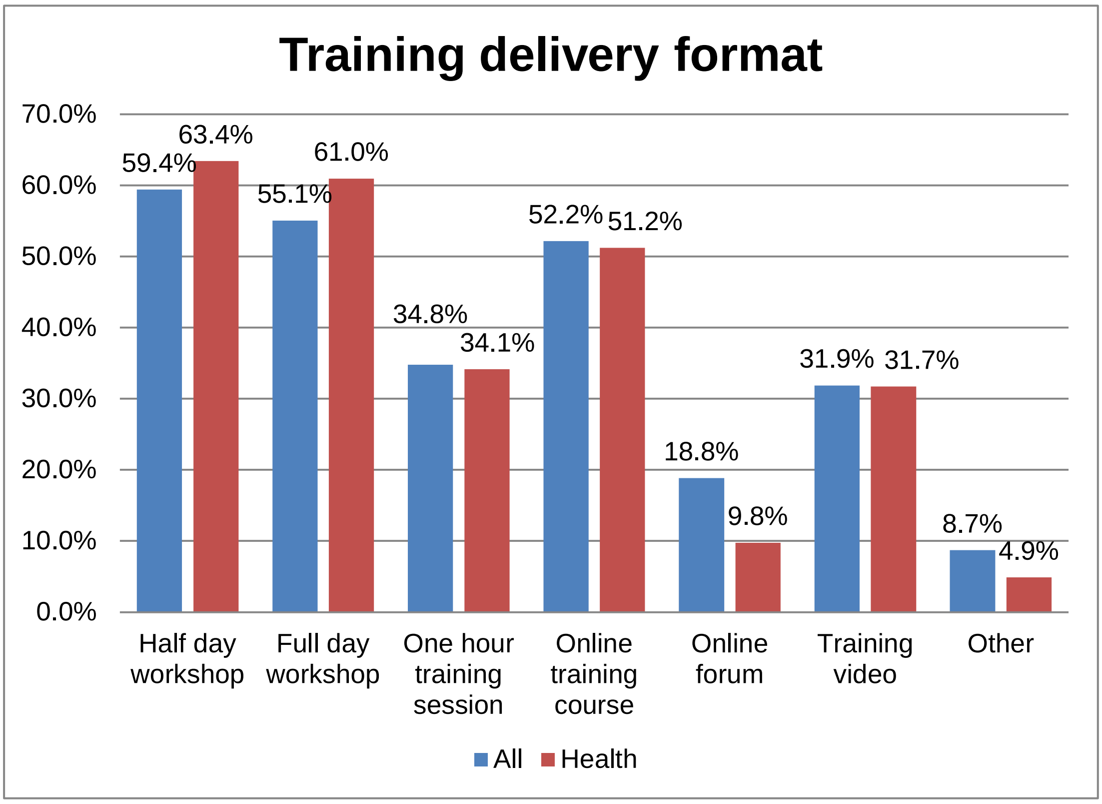
9.5 Training format

Alongside the topics which future training would be beneficial to include, the way that this training could best be structured was also considered. Participants were asked to comment on the length of the course, training delivery format and also the use of assessments.

Over half (59%) reported that a half day workshop would be of interest to them for accessing training. However, a full day workshop (55%) an online training (52%) were also formats which were identified by over half of those responding in this study. The results from those within the Health sector only were very similar, with half day workshops (63%), full day workshops (61%) and online training (51%) most reported.

A shorter format of training (one hour) was also of interest to over a third of participants (35%), while a training video was of interest to 32% of participants. An online forum was of interest to 19% of respondents.

Figure 27: Training delivery format

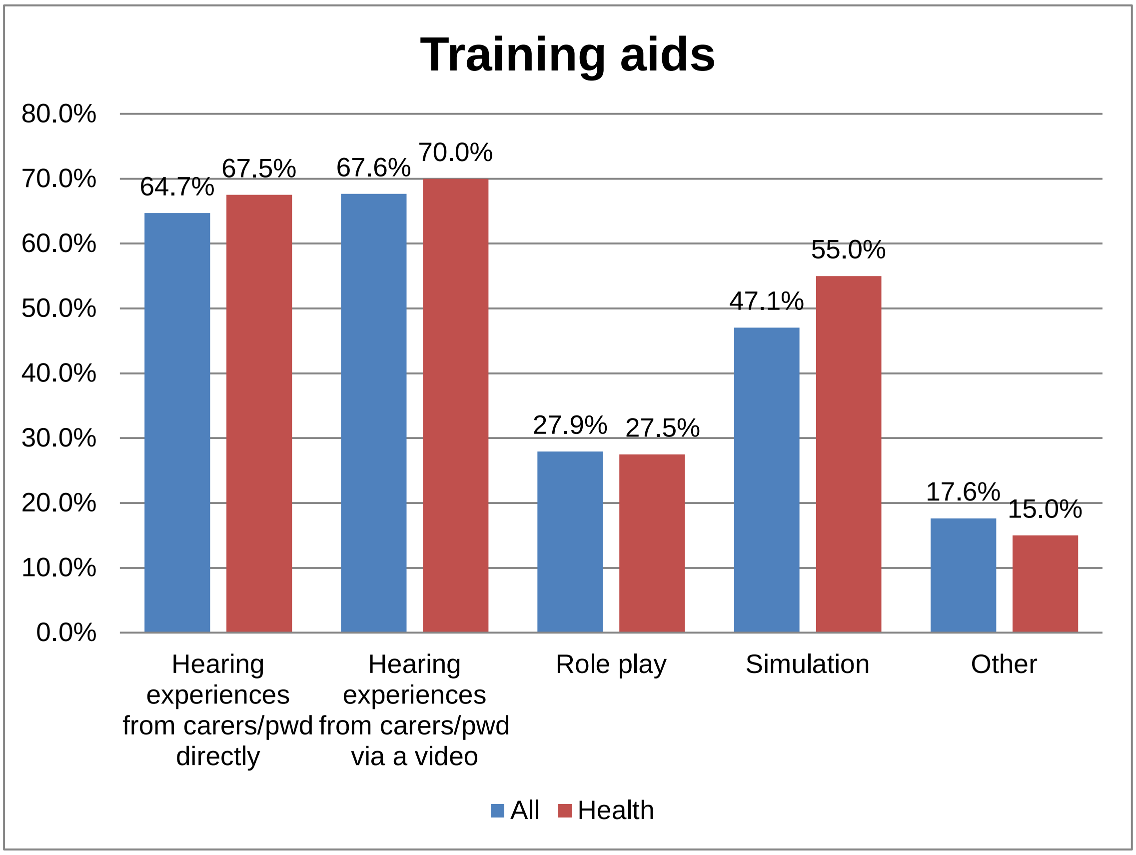


(Base: 69 all respondents; 41 Health, multiple response)

A ‘blended approach to learning’ was reported to be a useful approach by a couple of participants, who thought that a variety of methods would be most useful. While two participants also suggested that shorter sessions, such as lunchtime sessions, might encourage more attendance.

Participants were also asked to identify what additions to training would support their learning. Hearing the voices of carers and people with dementia was thought to be useful, either via a video (68%) or directly (65%), while simulation exercise or experiences were also thought to be useful by just under half (47%) of those responding in this study. Under a third (28%) reported that role play would be useful. For those within the Health sector, hearing the experiences of carers or people with dementia directly was thought to support learning by 70% of those responding and 55% thought simulation would be a valuable.

Figure 28: The use of training aids



(Base: 68 all respondents; 40 Health, multiple response)

A number of other suggestions were also made, with discussions amongst training attendees being useful, hearing real case studies and hearing from professionals being thought to valuable for including in training material.

‘Giving real case studies helps to make it real.’

‘Hearing tips and techniques from professionals working with people with dementia.’

Two participants also wanted to have more information about policy issues (social services and CQC for dentists).

One individual commented that all the proposed tools would be useful and shared an experience of having seen a video which had a particular impact: ‘I have already seen a video of carer experience … which I thought was excellent, providing a real insight into difficulties of living with someone with dementia’. While another participant also extolled the benefits of hearing from people living with dementia and/or cares, feeling that this should be the ‘first port of call’, although acknowledge that direct involvement in training may be difficult.

Similarly on participant shared a recent experience of having attended a simulation training session and thought that this had provided and ‘excellent’ experience.

9.5.1 Value of assessment

Participants were asked their views on attending a training course which has a formal assessment (e.g. an essay, reflective account, presentation). There was a mixed response to this, some were quite open to the idea, one even saying it was ‘excellent practice’, while others thought this would be a deterrent to attending and thought it was ‘impersonal’.

A number of participants were happy with this form of training, in principal, especially if it could lead to a qualification or more formal recognition of the value of the training. Similarly if such an assessment was able to promote greater engagement with the material and show the learning undertaken and to ‘check understanding’, this was thought to be a positive inclusion to training.

‘I would like a nationally recognised qualification if I had a formal assessment.’

‘I think it promotes engagement with the material and encourages deeper more productive processing.’

‘I think this is a great way of capturing how effective the training content has been presented. It allows people to express their individual experiences/interpretation of the content of the training.’

It was also suggested, by one participant, that the inclusion of an assessment process added kudos to the training and provided reassurances for people living with dementia and their carers that staff had attained a recognised level of skills and training. While another thought that this could improve motivation and develop staff portfolios.

‘It gives both management and families some degree of confidence that some staff have more than just a basic appreciation of the needs of people with dementia.’

However, there were some caveats to this. One participant asked whether there was evidence to support the use of formal assessments in training and whether this had a positive impact for patients. If so, then this individual was happy for such assessments to be included. This was also echoed by another participant, who commented: ‘Not worried as long as I am able to link theory to practice’.

Several participant thought that the inclusion of assessments was dependent on the length of the course and its aims, feeling that there was ’little reason to do an essay or reflective account for a half day or days training which can only really be seen as an awareness session’. Similarly, a couple of participants commented that a course for specialist dementia care staff or to develop specialist knowledge would be more appropriate for assessments.

One participant did feel that a reflective account of implementing training into practice could be of value. While another participant thought that such an assessment process would be best if supported by follow up training ‘to reinforce retention/application of learning’. This was supported by another participant who had undertaken a reflective process for their nurse training and felt it had aided in practice. As well as the use of reflective tools, the use of observation was also thought to be a good way to assess the way knowledge is put into practice.

Not everyone responding to this question was keen on the idea of an assessment process. Some thought this might be ‘difficult’, ‘too formal’, ‘onerous’ and one saying they would ‘hate it!’, that there could be an impact on staff time and therefore added pressures and stress for staff.

‘I feel pressure at work are high and it would put me off if I had to do a lot of extra work around updating my knowledge.’

The inclusion of an assessment in training would need to take into consideration the value and purpose of the assessment, the time input for participants to complete it and make this clear to participants.

Some clear messages, relevant to the delivery of the Dementia Academic Action Group project are evident from this online survey of staff and there are links with emerging themes from the other methodologies adopted in this study. These themes will be discussed in the next section, which draws together the conclusions from each of the finding sections (4 to 10).

10 Examples of best practice

This section highlights a selection of the examples of best practice which were discussed during the stakeholder interviews and/or were identified through the document analysis. These have been selected for a number of reasons, either they provide innovative ways of conducting dementia training, provide inclusive engagement for staff or have reported successful outcomes in practice.

Domiciliary Care Provider

One day in-house face-to-face dementia awareness training is offered to all care staff and is open to other staff members

This uses elements of SPECAL training: the photo album analogy
The day includes the use of videos and activities.

Dementia Friends is incorporated into the training to enable all staff to become Dementia Friends:

'…at the end of the dementia awareness … the staff get… given the opportunity to become dementia friends because … all of our trainers … are dementia champions, and we've incorporated the dementia friends training into the end of our awareness session.'

Training material is linked to practice situations and staff are required to undertaken an examination at the end of the training to achieve an expected 65% pass rate in order to progress to further training.

Trainers attend training, such as Dementia Mapping or SPECAL to ensure that their knowledge is up to date and that they continue to deliver current content.

This organisation has strong links with their community, delivering dementia awareness sessions and are looking for other ways to engage with the community, for example through coffee mornings.

Local Authority

This LA offer free short 2 hour workshops for care homes, nursing staff and domiciliary cares. Training is delivered by a trained Mental Health Nurse.

A range of workshops, of which the following include discussion on dementia:

- Dementia Awareness
- Dementia Friendly Environments
- Delirium
- Challenge of Caregiving
- Person Centre Planning
- Diet and Nutrition

Training is delivered within the work setting so that the delivery is close to the care setting, is easier to fit into staff working hours and is flexible. Additionally, the training provides an opportunity to talk in confidence about real issues and real experiences.

Family members and people with dementia are offered the opportunity to attend this training. This can help develop better understanding and relationships between the care service and the relatives/person with dementia.

Pre and post knowledge evaluations have shown an increase in knowledge development.

Care Home

Short 2 hour modular sessions are delivered to care staff. Examples include: person centred care, behaviours that challenge.

Staff are encouraged to discuss real life situations

'…because they're not having to be off the floor for a whole day with most of their care team, it can be done over lunch, for like a learning lunch. So in terms of practical application, breaking quite a lot of the information down into modules that take place over six weeks seems to be the most effective.'

A new mini module is being introduced to delivery sessions on the dementia pathway. This will include homework and a session using the virtual dementia tour.

Acute Hospital Trust

This Acute Hospital Trust has developed a range of training for different staff groups and is provided in different formats throughout the organisation.

Dementia Awareness Training has been delivered through new staff induction for qualified and Health Care Assistant inductions and the intention is to extend this to all new staff.

Practice educators within the trust have developed separate 1 hour long training sessions for clinical and support staff (including porters and housekeeping).These sessions use Barbara's story along with a PowerPoint presentation. The two sessions have different content tailored to different staff groups. The clinical session giving additional information on tools used within the hospital setting e.g. Lifestory booklet, hydration charts, Abbey pain scale plus details of the dementia CQUIN and referral process to Mental Health Liaison Team. Each ward has a Dementia Awareness Training toolkit. The executive Board have given the commitment to prioritize the releasing of staff to attend these sessions. The training is being provided on a rolling basis which enables staff to attend during lunch or change of shifts.

Enhanced training is available to develop Dementia Champions training which is open to all staff groups with the intention to promote best practice in dementia care within their wards/areas. This training is delivered on a modular basis. Additionally, ward based sessions are available which gives the opportunity to discuss particular issues that may have arisen within that care setting. There is an onsite Mental Health Liaison Team are available to provide training and expertise in the care of people with dementia.

11 Phase 1 conclusions

This section will review the key themes which cross cut across the different methodologies adopted for this review. These will also be considered in regard to the aim and objectives for this Phase 1 scoping review. The overall aim was to ascertain what dementia training is currently being delivered, within the Thames Valley region at Tier 1, with a view to informing the development of a coordinated approach to on-going and future dementia training in this region.

Over 50 different training courses were identified as being delivered within the Thames Valley region or which were run nationally and therefore also available to staff within the region. Through this section the way in which this can support the development of dementia training in the region will be discussed.

11.1 Review of Tier 1 training

A large number of training resources were identified at Tier 1, but it is unclear how many of these meet the necessary requirements in terms of Tier 1 competencies as outlined by the South West Dementia Partnership and the London Dementia Strategic Clinical Network. The quality of this training is also not clear or how training is aligned with practice. Some courses provided a wealth of information about the way the training was delivered, what content was included and how training would be delivered, but for others little publically available information was found, even when requests for further information were made, it was still difficult to identify what the course offered. This inconsistency in the level of information available on courses can make it challenging for services to access training and to ensure that it is going to meet their needs and the needs of their staff. From this review, the clarity of information about training would be an area for improvement for training providers to consider. Equally, the issue of quality was questioned and as such, the alignment of training with the quality mark, developed by Skills for Health, would seem one way of providing assurances of quality provision. Accessing information about training was not easy for some services and it was suggested that a comprehensive directory of available training would be helpful. Such a dementia training directory, outlining the level of training, topics covered and intended audience, would allow organisation to commission appropriate training based on the needs of their organisational workforce.

Training provision was variable not only in terms of content and perceived quality, but also by mode of delivery, and intended audience. Training courses were offered online, through face-to-face delivery, via video resources and also through a blended approach. Equally, the staff who are accessing training varies from service to service, with some providing training in dementia awareness for all staff and others focusing on the clinical, front facing staff. The debate regarding which staff should be accessing training is complex, with the needs of patients at the forefront of who should have training and services identifying which staff may meet people with dementia not always aligning. There was a general agreement from those taking part in this review that dementia awareness training should be open for all staff, regardless of role or level. While the actual content of the training may vary for those who have a more direct role in caring for a person with dementia, the promotion of dementia awareness training for all is something which would be a positive adoption for all services. In addition, the tailoring of training to specific staff roles would enhance its impact.

11.2 Gaps in current training provision

Gaps in training provision were reported through all elements of this review. Initially, content was considered in reference to the content of training, where the core competency areas of what is dementia, communication, person centred care, supporting people with dementia and developing activities with people with dementia were identified as a gap. These topics should be being delivered through the current provision of Tier 1 training; however, it was evident that services, staff and carers still feel these areas need to be covered further. The reasons why these core learning areas are still being seen as gaps is of concern as they are central objectives to nearly all of the training reviewed and form the basis of the Tier 1 training. Additionally, topic areas relating to policy, legislation and capacity were lacking in some of the training reviewed. Policy and legislation was also an area of interest to over half of those responding to the online survey and was raised by some of the stakeholders interviewed.

Other areas which were identified were: cultural and ethnicity, sexuality, end of life, comorbidities, learning disability, young people with dementia, positive environments and medication/prescribing. These may represent more specialist areas of knowledge within dementia training but were raised at different points throughout this review as gaps in the current provision.

Another area which could be developed is the emotional impact of care. Training content should provide examples of care offering and giving, especially since dementia is often understood as a stigmatised and fearful issue to discuss and experience. Health and social care staff should be afforded opportunities to learn about the emotional dimensions of caring for people with dementia, their families, their carers and themselves. In so doing, health and social care staff can be better prepared for the emotional aspects of dementia care in order to provide high quality and sensitive care in different scenarios (e.g. first diagnosis, coping with dementia, living with dementia etc.). Furthermore, health and social care staff can establish the necessary supports for themselves to enable them to provide the best care they can.

Communication, both verbal and non-verbal, is a key skill that should be targeted within dementia training. This should include how best to facilitate people with dementia to speak for themselves as much as possible while allowing family members/carers to share their experiences to identify their individual needs. The recognition of empathy within training is also important to develop within communication and has strong associations with the emotional aspects of dementia discussed.

The gaps in training did not focus solely on the content of training but this also incorporates the gap in knowledge transfer to practice. This was central across this report and is perhaps one of the reasons why there is such a strong need for training to continue to be delivered on the core competency topics. There is clearly some very good care practice in services across the Thames Valley region, however, the widely reported need for practical knowledge, implementable care skills and tips and techniques for practice suggests that this is an area which needs further development and review. Added to this is the suggestion that staff confidence could be better supported through training, particularly, it was reported, in reference to the development of practical skills.

The need for higher level training was also identified. The clarification of the Tier 2 and 3 competencies being a particular barrier to developing or delivering training at these levels. There is, however, a wide range of training available in dementia, at these higher levels. In addition, staff can develop knowledge in specialist areas, which provide in-depth learning and development of skills in communication, activities and person centred care.

Quite an important gap which was identified was the need for greater monitoring and evaluation of the impact of training. Some good examples were given where training is monitored both with staff measures but also practice measures, so for example staff absences, attrition, reflective practice and through supervisions and personal development reviews. Practice measures took into account patient and family feedback, number of incidents of pressure injuries, aggression, need for staff support, care mapping reviews and use of anti-psychotic medication. Formal and informal observations were also reported as a way of understanding the impact of training on staff and practice. The focus for this monitoring of training was very much about impact on practice, how was this of benefit to the patient and then subsequently to the staff and to the service.

11.3 Informing future dementia training provision

The definition of the tiers for dementia training and workforce development should be more clearly articulated and explicit in dementia training packages. Training packages pitched at different Tiers should align visibly with specific competencies. Moreover, training should be developed to meet the needs of different health and social care professions. For example, training packages should be tailored to meet the different roles/specialisms.

The need for signposting of services for both families/people with dementia and staff is an area which needs further development. The identification of local and national services could help to support information needs, specialist requirements and pathways of care. Dementia training should provide health and social care staff with a comprehensive overview of dementia services across the region. This might involve the collation of marketing/promotional materials prepared by dementia services for distribution to health and social care professionals.

Dementia policy documents emphasise the importance of both training and on-going workforce development. Much of the available training provision was organised in a short and ‘one-stop’ format, and not promoting continuous professional development. While shorter sessions which utilise e-learning/videos might be preferred given time and staffing constraints, there should be ‘blended learning’ organised over half/full day sessions which offer opportunities for staff to simulate care scenarios supplemented by e-learning/videos. This is especially the case for more advanced training. Furthermore, managers of health and social care staff should seek to evaluate the quality of care provided within their department/service, feedback as necessary to staff through staff development reviews and appraisals.

National dementia policy emphasises the importance of a cultural transformation in the health and social care response to the challenge of dementia. As such, while the nature and quality of training provided to health and social care staff is of paramount importance; if this training is not valued or viewed as part of the services core values/business, then such training is unlikely to improve the lives of people with dementia, their family and carers. Part of this cultural shift is not just about the embedding of training but also of ensuring the transfer of knowledge into practice through improved support for staff, by supporting staff to attend training and by considering ways in which person centred, individual care for people with dementia can become part of the everyday culture of an organisation, from policy to practice. A simple example of how this could be supported was given during the stakeholder interviews, where senior and junior staff attended training together so that learning and practice change could be implemented collaboratively and with a joined up approach. Other suggestions made to support this shift were the development of peer to peer support and the sharing of knowledge across organisations/staff groups. This shift in thinking would need to be supported at all levels within a service as well as by local and regional organisations.

There is a clear political and policy driver towards integrated and collaborative working both between the health and social care sector as well as specific disciplines within/across the health and social care sector. Therefore, while dementia training should be tailored to specific audiences/professions; it should also contain clear and consistent messages concerning inter-disciplinary working. This was exemplified in the need for shared patient notes and is evident with some services delivering or planning to deliver training to wider organisations within health and social care and within the community. However, this is something which could be supported to develop further.

The continued momentum and current drive to up skill both health and social care staff and the community in dementia awareness is evident through the policy and scoping elements of this review. Concerns were expressed that this was just driven by current thinking and that as soon as the next issue came, dementia would be forgotten. The importance of ensuring that dementia training is embedded within service policy and is driven from within organisations as well as externally through government legislation is therefore central to ensuring that dementia training remains on the agenda and continues to be supported and funded, therefore ensuring the legacy of dementia training.

11.4 Best practice example in current training provision

Best practice examples of training were identified within the local delivery of training but also nationally through the literature review. From these examples some key features emerge. Firstly, training has been tailored to a specific audience, so that it fits in with work patterns and work pressures (e.g. delivery in short sessions, on site and using relevant examples). Secondly, a blended approach to training delivery through the use of exercises, videos, and importantly, practical work based discussions, has been used. The inclusion of interdisciplinary approaches to learning in terms of delivering training to a range of different staff and including the family members and people with dementia was also identified as positive. While covering topics such as medication and end of life was also a positive step as it addresses some of the gaps which have been reported.

11.5 Supporting the carer and person with dementia

From this review, the support offered to carers and the person with dementia with regards to access to information and level of information available was discussed. There was a need to offer more signposting to information, provide greater clarity and depth of information, particularly in the early stages after diagnosis. The carers would have welcomed a one stop shop or carers pack which they could refer to. While some areas are providing support and information for carers, this was not thought to be available universally. Additionally, the development of greater support for the wider family and friends would be welcomed so that relationships could be better enabled and sustained. Fear and stigma of a diagnosis of dementia being reported here as reasons for social isolation. The associations here with greater engagement with the community should also be noted and that dementia awareness is an issue which still needs to be addressed within the wider community and not just focused on the health and social care services.

11.6 Summary of dementia policy implications

Dementia has risen highly on the political agenda resulting in a series of policy documents focussed on the enablement of people to live well with dementia. The provision and delivery of high quality dementia training and on-going workforce development is essential in order to meet the vision for dementia care. Improved awareness was seen as a fundamental mechanism to improve the earlier diagnosis of dementia while alleviating the fears held by the public about dementia. The analysis identified a series of dominant discourses which underpinned the formation of national dementia policy, which raise implications for the training and on-going workforce development of the health and social care workforce. These discourses have synergy with key issues emerging from the scoping activities and therefore warrant attention and consideration within dementia training.

11.7 Implications for dementia training from policy

11.7.1 Implications of discourses of dementia

- Dementia training could include content about the policy context in order to ensure knowledge of good practice and key drivers for changes within the health and social care arena. In so doing, health and social care staff will become more aware of the centrality of their roles to achieve the vision of the National Dementia Strategy and may demonstrate an increased motivation to change/update their working practices.

- Health and social care staff could be briefed about the health and social care reforms from the Health and Social Care Act 2012, and outline what their roles and responsibilities are within the National Dementia Policy.

- Health and social care staff could receive regular updates about dementia as part of continuous professional development. This should include information about dementia service provision available in their locality.

- Health and social care staff could be made aware of the neo-liberal rationale which underpins national dementia policy particularly concerning the drive to reduce costs via ‘spend to save’ and increased privatisation of services.

- Health and social care staff could be made aware that dementia is located as a driving force for positive societal change. This, therefore, places an emphasis on them as agents of change to translate dementia care into meaningful and positive social action.

- A realisation that living a good quality of life for people with dementia and their families/carers is not dependent on health and social care services. Instead, the integration of such services into everyday dementia friendly community context is paramount.

11.7.2 Implications of discourses of people with dementia

- Health and social care professionals need to fully grasp the intensity and implications of fear that surrounds experiences of living with dementia outside of the health and social care arena. Health and social care staff should be familiar with what that fear looks like from the perspectives of people with dementia and their families/carers.

- Health and social care staff need to understand the notion of stigma and how it applies to people with dementia and their carers. They need to work through their own ideas about dementia and how they intersect with notions of fear and stigma, and plan strategies and practices to ensure that their service provision counteracts experienced fear and socialised stigma.

- Dementia training should take into account the difficulties that both people with dementia (and their families/carers) and health and social care professionals have discussing dementia with patients. While increased awareness of dementia is very important to raising the profile of dementia;

health and social care staff should seek more proactive strategies to alleviating the fears associated with dementia such as positive role modelling of dementia; widespread provision of specialist services (e.g. memory clinics, dementia cafes, support groups); and apposite health and social care staff practises.

11.7.3 Implications of discourses of healthcare professionals

- Dementia training must address the fundamental misunderstandings that health and social care professionals have about dementia and the capabilities of people with dementia, including:
    - That nothing can be done for people with dementia;
    - Dementia is a normal part of the ageing process;
    - People with dementia lack the capability to make informed choices and decisions about their care;
    - That people with dementia require medication to contain behavioural disturbances.

- Health and social care professionals should be mindful of power dynamics between people with dementia, their families/carers and themselves. Training should be provided on the facilitation of evenly balanced care giving and care receiving that is appreciative of the expertise of all parties.

- The motivations of the people/groups receiving training should be considering in relation to the training content in order to increase the likelihood of positive implementation and change. In particular, economic justification align strongly with wider drivers underpinning health and social care policy and reform; thus the economic case for improved dementia awareness, care and provision should be overviewed in training sessions.

11.7.4 Implications of discourses of dementia training

- Empowerment is a complex concept. The health and social care workforce need to go beyond gatekeeping and advocacy and into active listening to the voices of people with dementia in order to ensure that person centred care progresses beyond rhetoric and into practice. Active listening requires staff to create environments in which people with dementia can share their thoughts, feelings, needs and desires. People with dementia are the experts on their own lives. This has to be recognised and fore fronted in all forms of care planning. Once thoughts, feelings, needs and desires are shared, the health and social care staff should seek to work with the person with dementia to effect changes if possible (reporting back on an agreed set of actions). Health and social care staff are experts on the medical and services provision aspects. Both sets of perspectives are equally valuable and conditions should be fostered that do not privilege one expertise over the other.

- Health and social care staff should have access to training in active listening and transforming knowledge gained into action. This is critical to person centred and individually-tailored care delivery in order to understand what a person with dementia wants and delivering it.

- Health and social care staff should receive training on how to deliver culturally sensitive care in the context of dementia. This should be cognisant of the intersections between gender, age and ethnicity. However, health and social care staff should not lose sight of the individual and their unique situations and requirements.

- Training should mindful of the heterogeneity of dementia as different forms of dementia have distinct disease trajectories and symptomisations. More should be done to ensure that differences are understood as well as similarities across conditions, and what such differences mean for living well with dementia in everyday life.

- The variability of contexts in which health and social care staff implement training should be recognised; and flexible strategies to adapt training within contexts should be considered within training programmes.

11.7.5 Implications of discourses of dementia awareness

- People come first and dementia is secondary to personhood. The training should emphasise the fact that people with dementia still have significant contributions to their relationships, their families and their communities. Furthermore, many people with dementia may continue to have family, work and leisure responsibilities. This cannot be achieved unless dementia awareness and dementia training is delivered collaboratively across public, private and voluntary/community organisations alongside the health and social care sector.

- People with dementia should be seen as valuable contributors to the development of the health and social care sectors as they progress towards realising the vision of the National Dementia Strategy. In this sense, people with dementia continue to be producers as well as consumers of the health and social care sector.

12 Implications for phase 2

The following provides implications for the development of the next phase of this project.

- The importance of gaining a clearer understanding of why there is a gap in knowledge transfer to practice would be important. This could be developed through a systematic review of the literature of knowledge transfer to identify how this is working in other fields and how it could be supported within dementia training.

- The delivery of training which has clear links with practice should also be encouraged. This can enable staff to talk about the issues they face, about care practices which are being delivered within their service and also provides the opportunity for peer-to-peer discussions about best practice, tips and shared experiences of care.

- A flexible and blended learning approach to the delivery of training would be most suitable for the health care services. An approach which offers short sessions, to accommodate staff availability, uses a mixture of face-to-face, eLearning, video, exercise etc. and one which can be tailored to the staff attending was identified as being suitable.

- Monitoring the impact of training, particularly on practice is important to be included in the future development of this project. Guidance for how other services can develop impact monitoring of their training would also provide a useful resource.

- One of the ways in which this project could be developed is through an understanding of the ways in which culture change within services can be better supported and recognised. This could provide baseline knowledge of what are the barriers and enablers of change, where change would be beneficial to a service and were it would impede, how change could be developed and what, if any, drivers there are for such change.

- Further considerations emerging from this review, but are perhaps outside of the scope of the next phase of this project are:

    - The development of a directory of training would prove a useful resource for many services, to include details of the level of provision, brief outline of the objectives and outcomes of the training and the training delivery style. This would be required not just for Tier 1 training but also levels Tier 2 and 3, higher education and specialist training courses.

    - Developing information resources for carers and family members, or providing signposts to this information would be valuable. For example a ‘one stop shop’ for information or a carer’s pack were suggested as potential resources.

13 Phase 2: Design and delivery of a Tier 1 dementia awareness training package

13.1 Introduction and background

The purpose of this section is to present the outcomes and outputs for Phase 2 of the project, which builds on findings and recommendations from the first phase.

Phase 2 consisted of the design and delivery of training materials/packages that covered all the expected learning outcomes for Tier 1 dementia awareness training. It was part of activities in the region in response to Health Education England's and the Department of Health's mandate to ensure 80% of NHS staff are trained in dementia awareness training at Tier 1 by the end of 2015. This mandate was revised and now states that by 2020, all NHS staff should have received training on dementia appropriate to their role (DH, 2015). Tier 1(Foundation level) training "familiarises staff managing patients affected by dementia with recognising and understanding dementia, interacting with those with dementia, and to be able to signpost patients and carers to appropriate support". This is the definition provided by the e-Learning for Healthcare education providers, formerly for Department of Health and, latterly, Health Education England.

13.2 Aims and objectives

The aim of Phase 2 of the project was to develop and deliver a sustainable model of Dementia Tier 1 training within the Thames Valley Region (see Figure 1).
Key objectives of Phase 2 were to:

1. Use the findings from Phase 1 to inform the planning and delivery of Tier 1 training;

2. Identify areas where there are gaps and variation in training delivery and develop a strategy in order to address these to improve quality;

3. Develop free to use Tier 1 dementia awareness training packages aligned with Skills for Health dementia curricula, providing a sustainable resource for HEE TV;

4. Use the evaluation of Phase 2 of Tier 1 dementia awareness training to inform future dementia training provision.

Phase 3 of the project was designed to provide a systematic evaluation of the core and extended Tier 1 training packages and their impact on clinical and non-clinical healthcare workers. This phase was designed to run concurrently with Phase 2 and will be described in section 22 of this report.

Training sessions were delivered across a wide range of venues across the region (see table 12). This included some larger and well-resourced venues, such as universities and a conference centre, through to small rooms in GP practices or at the back of a Community Hospital.

Table 12: Venues for training events

County	Venue
Oxfordshire	Witney Community Hospital, Witney
	Wantage Community Hospital, Wantage
	L&D Centre, Littlemore, Oxford
	Oxford Brookes University, Oxford
	Baptist Church Hall. Long Crendon
	The Rectory Centre, Oxford
	Oxford Brookes University/Fearndale Campus, Swindon
	Kassam Stadium, Oxford
	Wallingford Community Hospital, Wallingford
	Unipart Centre, Oxford
Buckinghamshire	Furzton GP practice, Milton Keynes
	Post Graduate Centre, Milton Keynes University Hospital Trust
	The John Hampden Surgery, Great Missenden
	Sovereign Medical Centre, Milton Keynes
	Central Milton Keynes Medical Centre, Milton Keynes
	Haddenham Medical Centre, Aylesbury
	Fairford Leys Surgery, Aylesbury
	Ridgeway Centre, Milton Keynes
	Orchard Surgery, Bourne End
	Hawthornden Surgery, Bourne End
Berkshire	Open learning Centre, Bracknell
	The Homestead Care Home Crowthorne
	Millman Road Surgery, Reading
	King Edward VII Hospital, Windsor
	Lambourne Medical Centre, Hungerford
	Dedworth Medical Centre, Windsor
	Maidenhead Golf Club, Maidenhead
	Wokingham Hospital, Wokingham
	UWL Fountain House, Reading
	Herschel Medical Centre, Slough
	Easthampstead Conference Centre, Wokingham
Outside the Thames Valley region	University of Northampton, Northampton
	Other, not specified

14 Design of the packages

14.1 Context

This section outlines the approach adopted in undertaking in the design and delivery of the training packages. The methods used for the early part of Phase 2 of the project involved the following key elements:

- Developing free to use Tier 1 dementia awareness training packages, incorporating the outcomes of Phase 1;
- Identify target areas in partnership with HEE TV where there is a need for such training to be delivered;
- Evaluate the delivery and impact of Tier 1 dementia awareness training (Phase 3) to run parallel to Phase 2, and to be completed in the spring of 2016.

The Phase 2 proposal, submitted in April 2015, recommended that the time frame for the delivery of Phase 2 training was an eight-month period from May 2015 through mid-December 2015.

14.2 Design

The need for improved awareness training was outlined in detail in section 4 of the Phase 1 report. The intent of the designers was to learn from the scoping undertaken in Phase 1 and from the existing training materials and packages by replicating those elements that clearly worked, whilst supplementing these with identified gaps to create a new product that was based on the current available evidence.

The scoping suggested that despite the range of training being delivered for health and social care staff, there were still some areas where training is not focusing or is not having an impact into practice. It identified gaps and barriers that needed to be considered in the design of the training materials, which included:

- Early diagnosis and recognition of symptoms; (WHO, 2012; WHO, 2015; NICE, 2013; Benbow et al. 2011)
- Understanding of the different types of dementia; ; (WHO, 2012; NICE, 2013; Benbow et al. 2011)
- Pharmacological treatments; (WHO, 2012; NICE, 2013)
- Application and principles of person centred care; ; (WHO, 2012; NICE, 2013; Benbow et al. 2011)
- Communication; (WHO, 2012; WHO, 2015; NICE, 2013; Benbow et al. 2011)
- Understanding ethical issues and principles; (WHO, 2012; NICE, 2013)
- Young people with dementia; (Westera et al., 2014)
- Cultural issues; (WHO, 2015; Pulsford et al., 2006).
- Time to be made available for training; (Ward and Dobson, 2014; Westera et al., 2014; Chater and Hughes, 2013)
- All staff should receive training (NHS Confederation, 2010: NHS Mandate 2015)

The scoping review also highlighted a wide range of existing packages already in use in the UK using many different delivery mechanisms, from formal classroom settings to complete online delivery.

The main recommendation on delivery was:

- A flexible and blended learning approach to the delivery of training would be most suitable for the health care services;
- An approach which offers short sessions, to accommodate staff availability, uses a mixture of face-to-face, eLearning, video, exercise etc. and one which can be tailored to the staff attending was identified as being suitable.

The designers therefore opted for a blended package design that included didactic components, discussions, reflection, use of videos and access to online resources.

Flexibility could be achieved through the insertion of different videos to suit particular audiences. However, in the first instance the aim was to create a generic package that would deliver Tier 1 learning outcomes, regardless of the nature of the audience: in other words, it should not appeal to a particular professional group, but appeal to all.

It was also not designed to go beyond the Tier 1 learning outcome and should be seen to be a starting point for most of the audience, whilst still functioning as a refresher and/or update for those who already had significant experience and knowledge of dementia.

14.3 Essential themes

Rather than start anew, it was agreed to use an existing training package designed by one of the dementia leads at Oxford Health NHS Trust, as a starting point for the new package. This already contained the majority of core requirements, i.e. definitions of dementia, the main types of dementia, risk factors and prevalence of dementia in the UK, early symptoms and the importance of early diagnosis, compassionate and person centred care, causes of challenging behaviour, signs of distress and behaviours that may communicate unmet needs and signposting people to sources of support and advice.

During design meetings, it was agreed that the presentation needed some enhancement of existing content, and some additional elements. These were UK and global policy context, the voices of people with dementia, young dementia, the impact of dementia on people with dementia and their families and carers, cultural and environmental adaptation issues, the newly published model for living well with dementia (Andrews, 2015) and activities to allow attendants to record some reflections or intentions to change as part of the sessions.

This would result in the total package both meeting our own expectations as well as the standards set out in draft versions of what was to become the ‘Dementia Core Skills Education and Training Framework’ (SfH, EE & SfC 2015). These elements will now be discussed in turn.

14.3.1 UK and global policy context

The designers wanted to reflect the political urgency and National and International policies and initiatives that have made dementia awareness such a priory (DH 2009, DH 2015, WHO 2012). The training package, therefore, carried three slides to highlight the UK priorities outlined in the National Dementia Strategy (DH 2009), with emphasis on the predicted rise in numbers, the need for better awareness, training and services, and the focus on ‘living well with dementia’. A slide on the G8 summit on the dementia (DH & Prime Minister’s Office, 2013) shows that dementia is now considered to be a global issue, and exemplifies the size of the challenge across the world in years to come.

14.3.2 Person centredness and the lived experience of dementia:

Person centredness has long been considered an important element of care delivery for people with dementia (Barnett, 2000; Brooker 2004; Whitman, 2016), and is now considered an essential requirement for all contemporary care delivery in health and social care for people with dementia (The Health Foundation, 2014; Hewitt-Taylor, 2015; Brooker & Latham 2016).

The package has several slides that relate to personhood (Kitwood, 1997) and person centred dementia care (Hewitt-Taylor, 2015; Brookes & Latham, 2016). At this point, the participants are reminded of the individual Activity 1 (“Forget Me Not”), undertaken at the start of the session. For this the participants are asked to consider themselves in the advanced stages of dementia, and no longer able to express their needs verbally. They are asked to write down the most important things they would want their carers to be aware of in terms of their own needs and preferences. This invariably gives a wide range of answers, exemplifying the need to identify each person’s individual strengths, desires and needs. Within this there is the opportunity to stress the need to consider individual variables such as cultural background. This will be further discusses in section 3.1.8.

The Oxford Health NHS Foundation Trust (OHT) presentation included the use of the video ‘Barbara’s Story’ (Guy's and St Thomas' NHS Foundation Trust, 2014). This is part of a training pack with compact discs containing six films created by nurses at Guy's and St Thomas' to raise awareness of dementia among staff, which is widely used as a recognised high quality training video. This is available free of charge via a training pack with compact discs, or via a YouTube link.

‘Barbara’s Story, the whole story’ is a professionally made video, following the lived experience of a fictitious person with dementia, played by an actress, and her journey from early symptoms to her eventual death. This journey includes several contacts with health care professionals, which gives clear examples of good practice, as well as rather poor practice, especially around communication.

The video shows how Barbara experiences her lived reality and her surroundings, which provides good examples of how people with dementia might retreat into the past and be confused about how they perceive the present. Within this there are examples of good practice, such as the use of photographs to overcome a situation where Barbara becomes confused and upset, and no longer recognises her own daughter. Other examples show how staff responded to her erroneous belief that her husband is still alive, and distracting rather than confronting her when she found wandering in a corridor.

It also provides good examples of the effects of sensory hypersensitivity in several scenes, for example where Barbara is taken to a busy A&E department. Sensory hypersensitivity (Crow 2014) and poor sensory integration (Jakob & Hillier, undated) are known factors in creating confusion and distress in some people with dementia. This is reflected in current guidance from Alzheimer Society (2012).

Another scene shows the use of red coloured food trays, now recognised as effective components of the use of colour in terms of aiding nutrition (NHS Choices 2015; JBI 2011) and environmental adjustment (DSDC, 2012).

The YouTube video ‘Barbara, the whole story’ was embedded into the package. The impact of the video can create significant emotional responses from an audience, with a very lifelike portrayal of living with dementia. However, although it is very well done, it is still an acted role. For this reason, the designers also include a video from SCIE TV (Social Care Institute for Excellence Television). The film, entitled ‘Living with dementia’ (SCIE 2014), shows how supportive relationships with families, friends and professional carers can play a key role in supporting people with dementia. In their words it is:

> “…a powerful reminder of the importance of getting to know the person with advancing dementia as an individual and to help support them to maintain their own identity” (SCIE, 2014).

It contains accounts of four people who have dementia, and who talk about their feelings and experiences around having the condition. It also includes the wife of one, and the daughter of another person, who give their perspectives as carers and relatives. They each show different symptoms and experiences of living with dementia. Although their descriptions are very different, they each contain both blunt descriptions of the challenges and frustrations caused by their dementia, as well as positive messages. During the pilot phase, there were very positive responses to both videos, and therefore it was decided to include these in the final package.

14.3.3 Young dementia

A slide was introduced to highlight the existence of early onset/young dementia. It goes on to emphasise the enhanced impact that young dementia can have when it affects someone in their 30’s or 40’s. Links are made with different expectations and demands of people in these age groups and the additional challenges this may pose for the person with a (frequently unexpected) diagnosis of early onset dementia and the families. To help support this slide, reference is made to the SCIE video, which contains two people who are examples of living with early onset dementia (Barry and Judith)

14.3.4 The impact of dementia on the person with dementia and their families and carers

In addition to the slide described above, there is a further slide to highlight the possible impact of having dementia on the physical, psychological, social and spiritual wellbeing of the person, associated with the likelihood of multiple losses and the need for adjustment. The individual nature of the different types of dementia, and variety of symptoms that can be experienced are emphasised. The message is that people will respond differently to their diagnosis and person centred approaches to dementia care require us to respect the individuality and different preferences and needs of each person with dementia.

14.3.5 Cultural issues

Cultural issues can no longer be ignored in the multicultural world that most people live in. Transcultural care and culturally sensitive care have been advocated since the late 50's by early nurse academics, such as Madeline Leininger (2002), and more recently in the UK by academics such as Helman (2007), Papadopoulos (2006) and Holland & Hogg (2010).

The situation has been described by the All Party Parliamentary Group on Dementia as:

> 'Current evidence in this area is limited, but it does indicate there might be lower awareness, higher levels of stigma, and different cultural understandings of dementia among people from BAME (Black, Asian & Minority Ethnic) communities.' (APPG on Dementia, 2013:7)

The instructions for the slide on person centred care stresses the importance of culture related to food (Halal/Kosher), festivals (Christmas/Ramadan/Purim/Divali) or religious practices (prayers/end of life rituals and burials).

The trainer can also indicate that in some languages, such as Japanese, there is no equivalent word for dementia (Maruta, Matsumoto & Kanba, 2013), where the term 'Idiocy' is used instead. In India, another negative term, 'madness in elderly', is sometimes used (Khan, 2011) exemplifying stigmatisation.

In terms of communication, it is worth pointing out that as linguistic skills may be declining, the person's original language is likely to remain intact the longest, as this is linked with long term memory and rote learning (Hyltenstam & Viberg 1993).

14.3.6 Environmental adaptation

It is well established that any environment can be made more dementia friendly by making some simple modifications and changes. The package includes guidance on the use of clear signage, lighting, and noise levels and other stimuli.

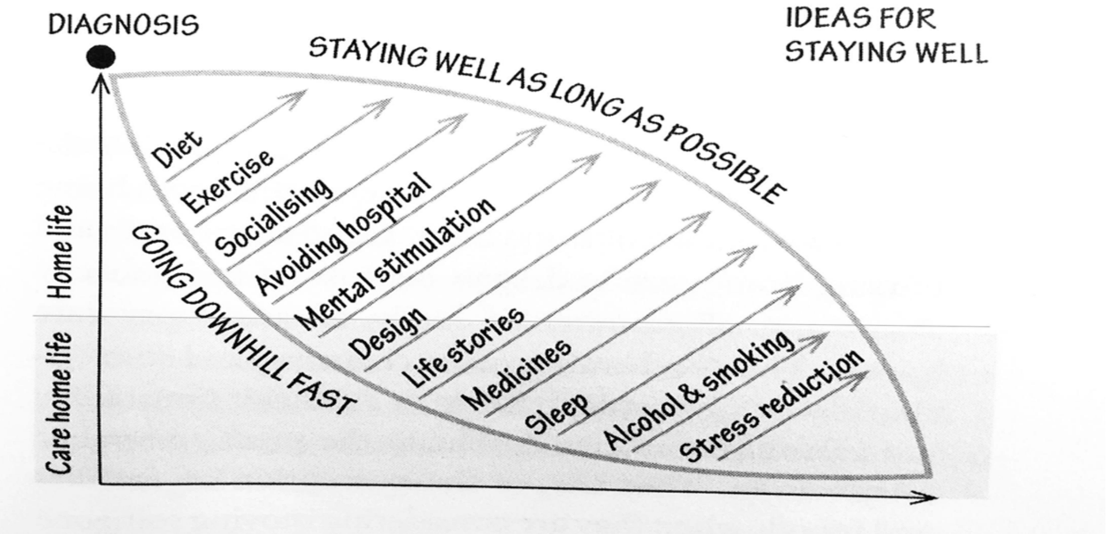
It advocates the use of colour contrast in relation to improving nutritional intake through the use of coloured crockery of aiding nutrition (NHS Choices 2015; JBI 2011), and coloured toilet seats to reduce falls) and environmental adjustment (DSDC, 2012).

Participants are referred to the extremely helpful resources available from the Dementia Services Development Centre at Stirling University. This includes their 'Virtual Care Home'. This is an online resource that provides examples of how kitchens, bedrooms and living rooms can be made more dementia friendly in terms of design, lighting and other adjustments. Participants are encouraged to visit the website at Stirling University to find out more.

14.3.7 Andrews model for living well with dementia

During the spring of 2015, Professor June Andrews published the 'Dementia - the one stop guide: Practical advice for families, professionals and people with Dementia and Alzheimer's Disease'. This contained a diagram that very clearly outlined the measures and interventions that can be used to slow down the development of the symptoms of dementia, and allow people to live well with dementia, and remain in their own homes for as long as possible (see figure 29). This neatly encapsulates the options for people with dementia and their carers in how to respond to a diagnosis of dementia.

Figure 29: Ideas for staying well



(Andrews 2015, p123)

14.3.8 Participant's personal experience, reflections and intentions to change

The designers included three activities within the package delivery. The first of these was individual Activity 1 ("Forget Me Not"), undertaken at the start of the session. For this the participants were asked to consider themselves in the advanced stages of dementia, and no longer able to express their needs verbally. They were asked to write down the most important things they would want their carers to be aware of in terms of their own needs and preferences. This invariably gives a wide range of answers, exemplifying the need to identify each person's individual strengths, desires, preferences and needs.

This was followed by Activity 2 ("Your perceptions of dementia"), for which participants were to work in pairs or trios to share their perceptions, professional or personal experiences of dementia. This gives the trainer a feel of the pre-existing knowledge and experience in the room, which can be referred to and utilised later. In our experience, the participants will express predominantly negative views or experiences. This is a good starting point for presenting the concept of 'living well with dementia' as the currently advocated perspective on dementia. This is reflected in the title of the National Dementia Strategy (DH 2009), which is covered a little later in the session.

The third activity was at the end of the session. This is where participants were asked to think back to the ‘Forget Me Not’ exercise and a few volunteers were asked what they wrote down on their statement. This should again reinforce that people write down different things, confirming the need to provide personalised and person centred care. In addition, it supports the use of ‘This is Me’ or ‘Knowing Me’ forms that allow for this information to be recorded and used in health and social care.

Following this, the participants are asked to reflect on what they have seen, heard and discussed during the session, and consider one thing they will stop doing and one thing they will start doing from now on, based on what they have learned.

The final slides were used to list a wide range of online national and local dementia resources and dementia Mobile applications or ‘apps’ available for iPhones and Androids.

Finally, attendees were encouraged to become a Dementia Friend as a way of raising wider awareness. The training package was formally recognised as meeting the standards required for Dementia Friends Training, as negotiated with the Alzheimer Society’s Dementia Friends scheme in June 2015. Therefore, the trainers were able to provide participants, who wished to become dementia friends with the requisite badges, pledge cards, and registration cards at the end of each session.

14.3.9 Additional themes

The pilot phases of delivering the training session had indicated that it would take approximately two hours to deliver, which had been the target timescale that the designers had identified as the ideal duration. However, having included the minimal required topics to cover the expected learning outcomes, a number of further topics were identified which had a better fit for those involved in regular care delivery for people with dementia, or were geared more towards Tier 2 level training in terms of focus, and therefore were less suited to a generic training package. This was either because they directly related to aspects of care delivery and/or contained more advanced levels of knowledge or related to skills.

These themes were:

- Emotional aspects of dementia – Carers
- Principles of good support
- The 3 D’s (Dementia, Depression & Delirium)
- Triangle of Care - Hannan et al, (2013)
- Communication and thinking
- Effective Communication exercise (VERA - Brooker & Lillyman 2013)
- Common Behavioural Symptoms in Dementia (James, 2015)
- Decision Making & Dementia, Mental Capacity Act (2005) and other legal issues

It was decided that these might be offered as an ‘extended’ package, lasting an extra hour in length. The term ‘extended’ was chosen to indicate that anyone taking this session was to have undertaken Tier 1 dementia awareness training beforehand, but would like to further develop their understanding and skills in the above areas. The Extended Package was designed to provide a refresher about what dementia is, the diagnostic process, and how the inter-related conditions of delirium, dementia and depression can manifest themselves during that process, and potentially create confusion (Downing et al, 2013).

The participants were to be shown a Social Care Institute for Excellence (SCIE) video regarding the lived experience of being diagnosed with dementia from the perspectives of the person with dementia, entitled “Getting to know the person with dementia – Impact of Diagnosis”.

The package also introduced some principles of good support, including the ‘Triangle of Care’, which describes a therapeutic relationship between the person with dementia (patient), staff member and carer that promotes safety, supports communication and sustains wellbeing (Hannan et al 2013).

Participants were helped to consider the emotional impact of the diagnosis of dementia for carers and encouraged to think about the legal and ethical issues surrounding mental capacity and consent in the person with dementia.

A total of four activities are included in the package, one of which introduces the use of the ‘VERA’ method in communication with people with dementia (Brooker & Lillyman 2013), which stands for:

Validation

Emotion

Re-assure

Activity

In groups participants were asked to create responses based on these four principles related to a case study.

Discussion was encouraged of the more common challenging behaviours associated with people with dementia, which are:

- Aggression
- Anxiety and Agitation
- Depression
- Hallucinations or Delusions
- Sleeplessness
- Wandering
- Repeating the same conversation

(Adapted from James, 2015)

Finally, there was discussion around a number of legal and ethical issues, including the Mental Capacity Act 2005, Advanced Directives, Lasting Power of Attorney and the role of the Court of Protection. The final section addresses the Deprivation of Liberty Safeguards and use of chemical or other forms of restraint.

As with the standard package, the final slides were used to list a wide range of online national and local dementia resources and dementia apps available for iPhones and Androids.

By combining the ‘standard’ and ‘extended’ package, this training could be amalgamated to provide the two packages in one session. It could be delivered in three hours in order to meet the needs of service providers, especially where there can be issues with releasing staff to attend training. A small number of organisations took up the offer of undertaking both packages, but most opted only for the ‘standard’ package, quoting lack of time as the reason for not doing both.

14.4 Target audience

14.4.1 Identification

At the start of the project, early discussions suggested the Tier 1 dementia awareness training should be delivered to any organisation, such as banks, schools and the police force, but over time, the identified target audience changed to NHS service providers only, as this reflected Health Education England’s priorities.

HEE TV asked the DAAG to deliver the training packages across the whole region, but with a targeted emphasis on a number of GP practices who had been given additional funding to help them become ‘Dementia Friendly’ GP practices. The same applied to the Windsor, Ascot & Maidenhead (WAM) Clinical Commissioning Group (CCG). Other priorities were Oxford Health NHS Foundation Trust and Milton Keynes University Hospital NHS Foundation Trust who were comparatively low in achieving their targets for delivering Tier 1 dementia awareness training to their staff.

14.4.2 Consultation and pilot phase

The designers discussed their draft packages with the rest of the DAAG membership during a meeting on 31st March 2015. In order to test out the feasibility of using these packages, pilot sites in general practice; acute in-patient hospital settings and community services were identified. Three GP practices were involved in the pilot phase, all of which were part of the HEE TV “Dementia Friendly GP practice Project”.

Training was delivered in March and April 2015 to 80 participants including General Practitioners (GPs); Dentists; Nurses; Health Care Assistants (HCAs); Receptionists; Domestic Staff; Porters and Patient Representatives.

Feedback from the pilot phase included the following comments:

‘This session helped me to understand the strange behaviour of my grandmother when I was young.’ (a Polish Hospital Porter)

‘We are having to give dementia awareness training focus because of its effect on acute hospitals, one in four of our beds will by occupied by someone with dementia’ (Acute Hospital Trust Representative)

‘As a GP this training session really reminded me of the emotional impact of dementia on the patient and those around them! To see the person behind the condition.’ (a GP who attended a pilot training session)

Following the piloting of the training packages, the official training delivery was approved and launched in May 2015 and ran until 11 December 2015.

In line with HEE TV requirements and pilot site training needs, DAAG was initially set to provide a total of 192 sessions with each session having the capacity to accommodate 24 participants (3,456 delegates). These calculations were based on the proposal that two trainers will deliver 24 sessions per month, which totals eight days training over a one-month period. No training was to be scheduled in August or the Christmas period in 2015. The final sessions were to be delivered on 11 December in order to allow sufficient time for the evaluations to be processed within the timeframes of the evaluation phase (Phase 3) of the project.

Every opportunity was used to ensure DAAG and project sites maximised learning opportunities, and for participants to make the most of allocated time. A minimum number of five delegates were identified as being required, in order to make a viable session.

In some settings, these numbers might need to be flexible in order to meet the needs of the some organisations. For example, in primary practice, it was envisaged that there might be slightly fewer participants who might be present at a session, in order for the GP practice to continue to operate with minimal disruption. The actual size of group varied from 6 to 112. A full breakdown of the attendance is provided in section 15.

In order to balance the workload of Phase 2 and Phase 3, the University of West London aimed to deliver 30 (20 standard and 10 extended) sessions to their allocated pilot sites. The remaining partner universities aimed to deliver 54 sessions each across the Thames Valley region.

14.5 Permissions for resources

Permissions were sought and granted for the use of videos from Guy's and St Thomas' NHS Foundation Trust and Social Care Institute for Excellence (SCIE).

15 Details of sessions and participants

15.1 Total delivered

To record details of those attending the sessions, a spread sheet was maintained by the trainers, which contained the venues, details of the participants, job/professional titles, employing organisations, type of package delivered and dates of delivery. This data was used to compile this section.

At the end of the project, a total of 1471 had attended sessions in which the Tier 1 dementia awareness training package was utilised. Of these 309 participants were excluded from the evaluation of the project on the basis that they either did not receive the full package (e.g. through time restraints), or did not meet the criteria for the target audience (e.g. university students).

Finally, two sessions were delivered in Bracknell at the request of local service providers, which used a modified version of the package that focussed on the specific issues in dementia and people with a learning disability. This was attended by 27 people, consisting of health care assistants and a variety of health and social care professionals.

Most of the participants were identified and put forward by service providers and employing organisations, except for a conference day organised by Oxford Brookes University in 15th July. This was advertised across the region as open to anyone working in health or social care. It consisted of two parts. In the morning the Tier 1 dementia awareness training package was delivered, and the afternoon was devoted to challenging behaviour and dementia. Participants could either attend the morning or afternoon sessions only, or opt to attend both. The morning audience was 112, and they were given the DAAG standard package. The focus of the afternoon was ‘challenging behaviour in dementia’. This was delivered by a Principal Lecturer in Clinical Health Care and Senior Lecturer in Occupational Therapy from Oxford Brookes University and Consultant Clinical Psychologist from Oxford Health NHS Trust.

15.2 Breakdown of professional titles and roles

The data collected included the professional roles and titles of attendants to the training sessions. For the full list of job titles and roles please see Appendix 5. These were analysed and classified using the HEE guidance identifying staff into the staff groups required for the dementia Tier 1 training collection templates. These groups were:

1. Medical and Dental Staff
2. Registered Nursing
3. Qualified Scientific Therapeutic and Technical Staff (Including Allied Health Professionals, Healthcare Scientists, and Other Scientific, Therapeutic and Technical Staff)
4. Qualified Ambulance Staff
5. Support to Clinical Staff
6. Infrastructure Support
7. Others

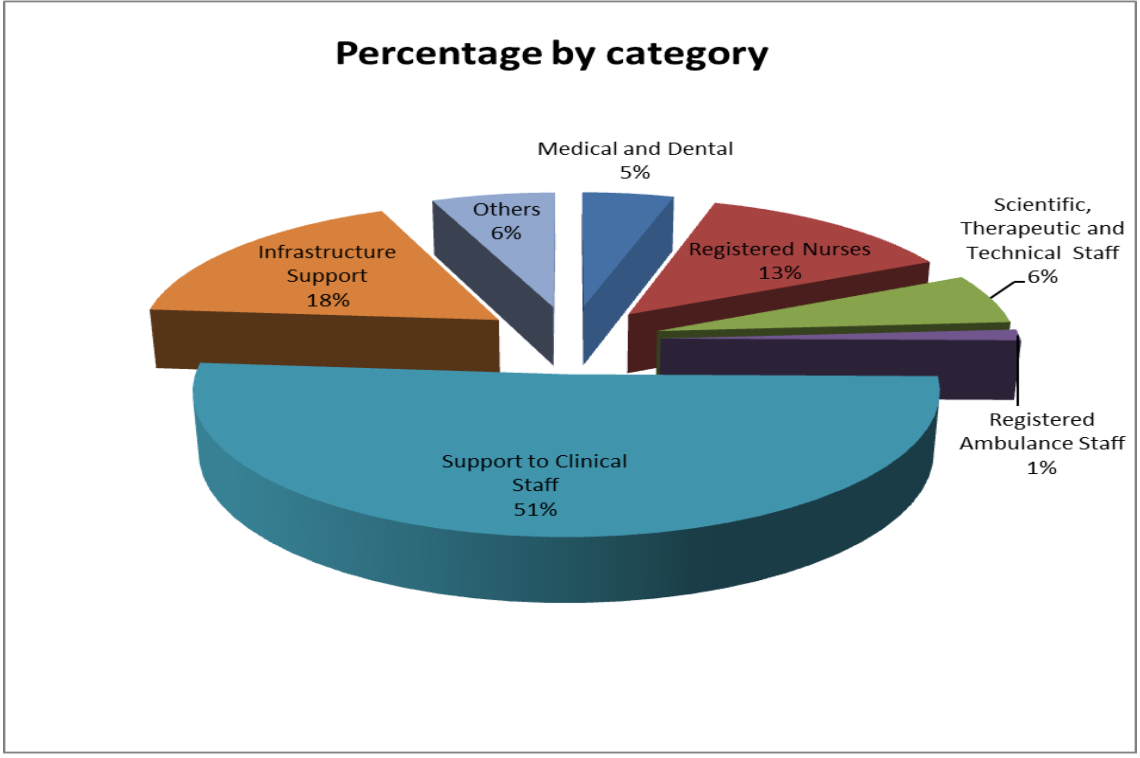
The numbers and percentages by category can be seen in the following tables:

Table 13: Numbers by HEE reporting professional categories

Professional category	No
Medical and Dental	69
Registered Nurses	196
Scientific, Therapeutic and Technical Staff	87
Registered Ambulance Staff	19
Support to Clinical Staff	752
Infrastructure Support	256
Others	93

The largest group was 'Support to Clinical Staff', with a total of 752 participants. This constituted just over half (51%) of the total number of participants. Within this the sub categories with the largest numbers were students (250), (Health) Care assistant (149) and support workers (70). There was significant diversity within this category, with 79 different job titles or descriptions.

Figure 30: Percentage representation of professional categories



15.3 Employing organisations

Most of the participants were employed in some capacity in the health and social care sector. The full list of employers can be found in Tables 14, 15 & 16. It was not always possible to identify which category the places of employment or employing organisations fitted into. For example, care homes may or may not have had NHS contracts within the service delivery. For this reason care homes were included in the -private and third sector category.

The following tables provide information on the different employing organisations by categories and the numbers of employees that attended the Tier 1 dementia awareness training events. Table 14 lists the numbers of organisation represented in each of the categories.

Table 14: Numbers per category of employing organisations

Organisations	No
NHS organisations	11
GP practice/Medical Centres	46
Social Services	2
Private and Third sector	40
Universities (students & staff)	3

The next figure gives the number of attendees by the type of employing organisation. For a small number of these (n = 24 or 2%), the employers were unknown or not provided. These could include some that were volunteers or others not in any type of formal employment.

Figure 31: Graph of numbers of attendees by employing organisations

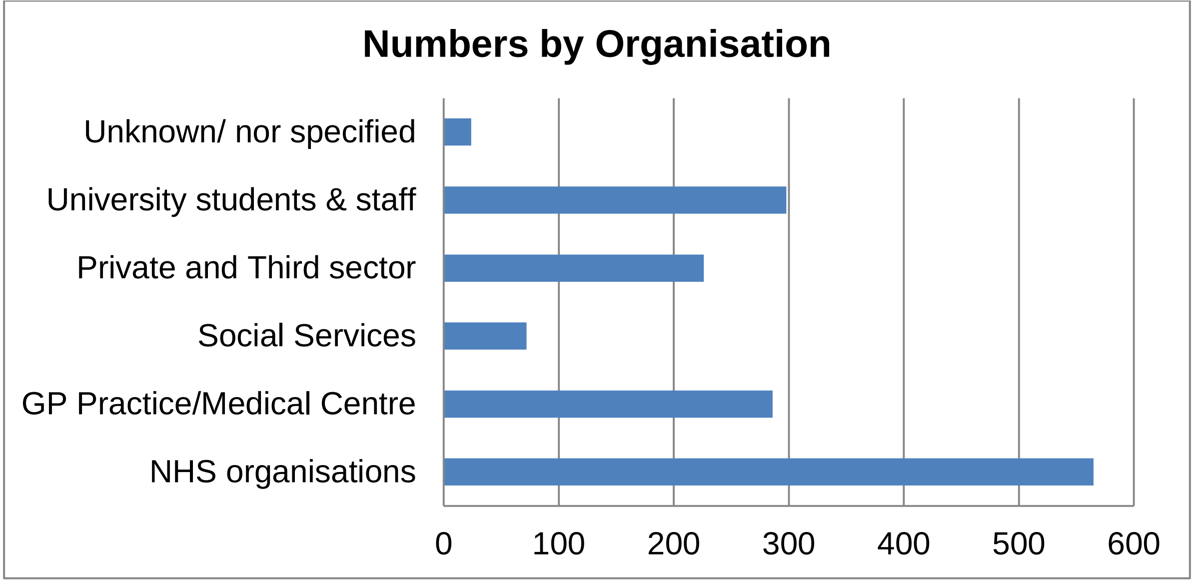


Figure 32: Percentage representation of employing organisations

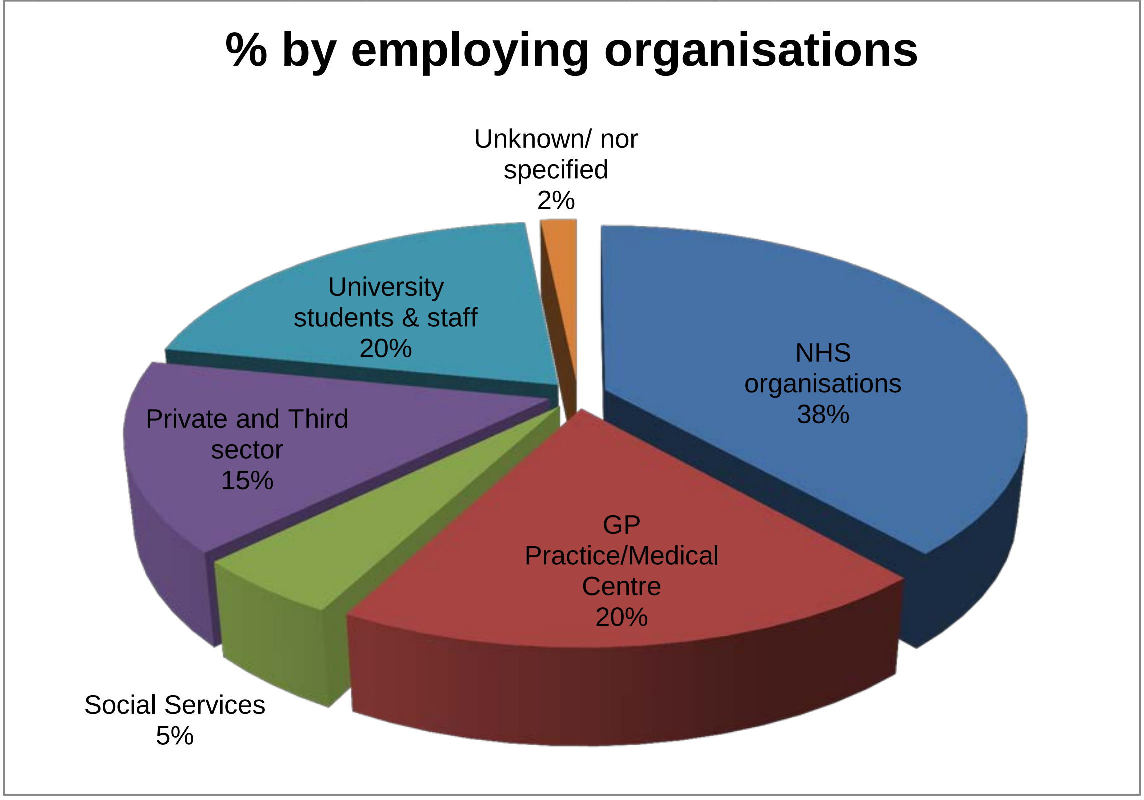


Table 15: List of category of organisations and numbers of participants

Organisations	No
NHS organisations	565
GP practice/Medical Centre	286
Social Services	72
Private and Third sector	226
University students & staff	298
Unknown/ not specified	24

As can be seen in Figure 32 and Table 15, The NHS organisations were represented the most in percentage terms (38%) and numerically (n = 565). Of these, three local NHS Trusts involved in the project had contributed the highest numbers of participants (combined n = 549) within the NHS category. The range was 1 to 275. OHT was the largest individual contributor of participants (n = 275 or 49%). Next biggest was MKUHT (n = 177 or 31%), followed by BHFT (n =98 or 17%). The list includes seven individuals who put down 'NHS' as their employer without further specification.

A total of 46 GP practices and medical centres that were represented in the project. The range in numbers of participants was 1 to 41. The latter was Trinity Health, who, as a group of three GP practices, were involved in the pilot phase as part of the process of becoming 'Dementia Friendly' practices.

There were 40 organisations from the private and voluntary sector in the project, and the range of participants was 1 to 24. Of those organisations which were not related to NHS or other health care providers, the largest group in this category were University staff and students, with a combined total of 198.

15.4 Sites and settings

The trainers used a wide variety of settings across the three counties. A total of 35 different venues were used, a number of which were used multiple times. The largest venue was the main lecture theatre at Oxford Brookes University. The smallest included a session delivered in a GP practice waiting room and a backroom in a Community Hospital. The majority were delivered in training rooms of varying sizes provided by the organisations for which the training was delivered, but also included a community college, a conference centre, and a church hall.

16 Phase 2 training delivery plan

The time frame for the delivery of the Tier 1 dementia awareness training packages was across an eight-month period from May 2015 through mid-December 2015.

This section reports on the significant role of the four facilitators and their involvement in the execution of the Phase 2 delivery plan. Activities included engagement with the identified target organisations; launching the DAAG Project and introducing the Tier 1 dementia awareness training packages; assessing the training needs for the target organisations, and finally planning the delivery dates, times and venues for the training sessions.

Three of the facilitators were involved in the conceptualisation, development and design of the training packages, therefore it was appropriate for them to be involved in the delivery. A fourth facilitator was drafted in to support the delivery stage after the packages had already been designed. This proved to be advantageous because they bought in a fresh perspective to the delivery phase of the project, and were able to give objective feedback about the quality of the training packages.

16.1 The initial phase

In the initial phase of the delivery plan, three project team members from University of Bedfordshire, Oxford Brookes University and University of West London were tasked with contacting the identified target organisations which had been allocated by HEE TV commissioners. The purpose of making contact was to establish links and partnerships with a view to recruiting participants into Phase 2 of the project. Target organisations were identified from the primary care sector, which included one Clinical Commissioning Group (CCG), three GP practices that were already engage in a Dementia Friendly GP Project and from secondary services which included large acute inpatient hospital settings. Tertiary services included community based services, such as care homes that were located across the Thames Valley region.

Project team members, as shown in Table 16 below, made contact with the target organisations and engaged in collaborative working. This resulted in the identification of local training needs, which were then matched against the Tier 1 dementia awareness training packages that were developed by the DAAG.

Table 16: Identified target organisations and allocated DAAG facilitators

	Sector	Area	Collaborations	DAAG Facilitator
1	Primary Care	Windsor, Ascot & Maidenhead Clinical Commissioning Group (CCG)	HEE TV & DAAG	University of West London
2	Primary Care	GP practice in Brill, Buckinghamshire	HEE TV, Strategic Clinical Network (SCN) & DAAG	Oxford Brookes University
3	Primary Care	GP Surgery in Prestwood, Buckinghamshire	HEE TV, Strategic Clinical Network (SCN) & DAAG	University of Bedfordshire
4	Primary Care	GP Surgery in Milton Keynes	HEE TV, Strategic Clinical Network (SCN) & DAAG	University of Bedfordshire
5	Secondary Care	University Hospital Foundation NHS Trust in Milton Keynes	HEE TV & DAAG	University of Bedfordshire
6	Secondary Care	Acute Hospital & Community Foundation NHS Trust in Oxfordshire	HEE TV & DAAG	Oxford Brookes University
7	Tertiary Care	Care Homes in Berkshire Area	HEE TV & DAAG	University of West London

NB* It should be noted these were the initial targets, and as the project progressed, the targets were extended. The facilitator from the University of Northampton became involved in delivering sessions in support of colleagues from UoB and UWL as part of the on-going collaboration between the partners in the DAAG project.

The next section will outline the following activities that were undertaken by the facilitators:

- Engagement with the identified target organisations
- Assessment of Tier 1 dementia awareness training needs and launching the DAAG Project
- Planning the sessions dates, times and venues in partnership with target organisations.

16.2 Engagement with the identified target organisations

Facilitators used various means in order to engage with identified target organisations and introduce them to the work of the. For some smaller organisations, contact was made by e-mail, which led to a telephone conversation and subsequently the dissemination of information about the Tier 1 dementia awareness training packages that were being offered.

All organisations received a briefing about the standard and extended packages. Some facilitators arranged face-to-face meetings at mutually convenient times, as a forum for further engagement and discussion about the DAAG Project. One organisation requested an official presentation about the DAAG project, and a preview of what the packages looked like in order for them to decide if it would be suitable for their organisation. This is reflected in the following facilitator comment:

‘The Local Authority and two the Clinical Commissioning Groups (CCGs) wanted to review the packages before recommending sending any of their staff.’

Whilst this was essential work that was needed in order to establish a firm foundation for the launching of the DAAG training packages, facilitators described how it took a considerable amount of time to organise all these preliminary meetings and e-mail correspondence with the interested organisations. One facilitator stated:

‘Time spent outlining the packages to partners was time consuming and needs to be considered.’

Some organisations initially engaged well when the DAAG project was launched and had committed to sending staff to attend the Tier 1 training. However, as time went by, there was some disengagement which meant that facilitators had to spend time trying to reconnect with them, as well as recruiting new organisations. A facilitator stated that:

‘Considerable amount of time was spent chasing after some organisations who had previously committed to send staff to attend the training.’

This highlighted the reality of the competing demands facing organisations, and that whilst they were interested in accessing the DAAG training packages, there were other priorities that meant that this did not happen. This factor needs to be taken into consideration for further projects which may wish to develop dementia training at whatever level.

The DAAG training packages were also launched at a Dementia Leads Forum that was associated with HEE TV, at the Strategic Clinical Network (SCN) which was running a Dementia Friendly GP Project as well as at a HEE TV funded Practice Manager’s Study Day hosted by the Postgraduate Medical, Dental Education and General Practice in Oxfordshire in June 2015. Such forums generated interest in the DAAG training packages, which resulted in other primary care organisations expressing an interest in the Tier 1 training. As the project progressed, the training was also promoted through the CCG networks, GP surgeries, pharmacies and dental practices. With the publication of the Mandate (DH 2015), there was a political drive that was pushing forward the Tier 1 training agenda; therefore, there was an overall interest in Tier 1 training.

Once the DAAG training packages were launched, the facilitators then went on to assess the organisational training needs and to match these to the DAAG training package. The next section will report on the outcome of this important facilitator activity.

16.3 Assessment of organisational training needs

Once facilitators had engaged with the target organisations, the next stage was to undertake a comprehensive assessment of differing organisational training needs based upon the numbers that needed to be trained. There were a number of factors that motivated organisations to want to receive Tier 1 dementia awareness training provided by the DAAG. National policy and targets were a significant factor. One facilitator stated:

‘The CQUIN and CQC compliance have made dementia training a priority for some organisations.’

Some organisations felt that they had already reached their Tier 1 training targets; they were more interested in Tier 2 training for the clinical staff. However, when facilitators explained that the DAAG training packages were designed to be delivered to a mixed audience of clinical and non-clinical health and social care staff, there were mixed responses to this idea. Some Care Homes did not necessarily subscribe to this point of view, and they tended to make decisions about what type of content would be suitable for non-clinical staff.

This assessment phase also revealed that some organisations were interested in having content added to the DAAG sessions, in order to meet their organisational priorities, without appreciating that this package was being delivered to a wide audience in order to meet nationally agreed Skills for Health Tier 1 learning outcomes.

For example, in primary care practice, there was an interest in the ISPACE initiative which was developed in 2011 by the Royal College of Nursing (RCN) following a survey of over 700 practitioners and 1480 people with dementia, their relatives, carers and significant others. The I stands for ‘identify a Dementia Champion’; S stands for ‘Staff who are skilled and have time to care’; P stands for ‘Partnership working with carers, family and friends’; A stands for ‘Assessment and early identification of dementia’ and E stands for ‘Environments that are dementia friendly’ (RCN, 2011). These observations are reflected in the following facilitator comments:

‘The Extended package was considered to be too detailed for some staff (for example housekeeping staff) but not detailed enough for other staff such as care home managers who would receive ‘Mental Capacity Act’ as a whole days’ training.’ (Care Home Setting)

‘Some organisations wanted certain things added to address their organisational priorities. For example how to manage falls, the use of the principles such as ISPACE.’ (GP practice)

‘Tier 2 training around behaviour that challenges requested by numerous care home staff.’ (Care Home Setting)

These comments highlight the importance of assessing the training needs of organisations. Whilst some organisations were keen to put their own training agendas on the table, the majority of the organisations contacted were happy with the idea that a package had been put together and would be available free to their organisations.

All facilitators engaged in open dialogue about the training packages, and they worked in collaboration with the target organisations. The fact that the training was being delivered for free was very appealing to all organisations, as reflected in the following comments:

‘The free aspect of the training was well received, care homes and domiciliary care requested additional training sessions.’

‘Some care homes have paid for Tier 1 dementia training for their support staff so felt our DAAG training would act as an update-although high staff turnover a recognised issue.’

Facilitators were also mindful to maintain a flexible approach, whilst ensuring that the target organisations remained in control of the decisions that were made. In other words, all facilitators recognised that patient care comes first and they managed to establish partnership working with the target organisations, which was essential to the success of the next planning phase.

16.3.1 Planning delivery of the Tier 1 dementia awareness training Sessions

As discussed earlier in this report, each facilitator had an agreed number of sessions and dates which were offered to target organisations. For some organisations, there were clear parameters that were set. For example, one acute hospital trust stipulated that training should not be delivered on Mondays, Fridays, during the first week of each month because that was when NHS Trust Inductions for new starters were done or during half term weeks as some hospital staff tended to take annual leave. In this instance, the facilitator had to re-arrange a number of sessions, in order to meet these parameters and to respect the wishes of this organisation.

With reference to primary care trusts, facilitators faced the challenge of accessing “GP Protected Learning Time” which, in one region, happened on the same Wednesday afternoon across the whole CCG. It was a challenge to fit in Tier 1 training in some areas as some dates were already allocated to predetermined “hot topics” and the timetable needed to be moved in order to fit in the Tier 1 dementia awareness training. One facilitator stated:

‘Protected learning time subjects were allocated some time in advance and were often linked to ‘hot topics’.’

‘We have already allocated all our sessions according to our organisational priorities, therefore we are unable to fit in anymore training during your Phase 2 delivery time frame which ends in December 2015. We can fit something in early 2016.’ (GP practice)

Despite not having heard the content of the sessions, some GPs commented on the length of the training sessions, stating that two hours was too long a time to try to fit into a busy lunch break. This was reflected in the following comment made by this facilitator:

‘I had a comment from two GP’s who said that the two hour training was difficult to accommodate within practices (often training delivered in lunch sessions). They suggested a compromise of e-learning for knowledge aspects and face-to-face for communication tools.’

However, the GP surgeries that were registered on the “Dementia Friendly GP Project” had a more positive and accommodating approach. They were anticipating the involvement of the DAAG in their training delivery, hence it was much easier for dates to be set with these GP surgeries and they were happy with the suggested time frames for the delivery of the Tier 1 dementia awareness training.

16.4 Advertising Tier 1 dementia awareness training to staff

Bespoke advertising flyers with details about the Tier 1 dementia awareness training were created by the DAAG project team and circulated to participating organisations that required them. These organisations were then charged with cascading these advertising flyers to all staff. It was in the form of a template which, prior to circulation, needed to be edited to include the name and contact details of the host organisation’s administrator who would be the central point of contact for staff interested in attending the training. Once the host organisation had added these details, the flyer was then ready to circulate to all relevant staff.

One acute hospital trust had a special advert put on every employees computer as a pop up which would appear each time they logged in to the system whilst the Dementia Lead Nurse actively highlighted the dementia training each time they visited clinical areas and departments. Notifications were also made on some CCG bulletins and mailshots were undertaken. Another Trust included the sessions in a pre-existing programme of Tier 1 Dementia Awareness training activities.

There were instances when the agreed advertising strategy was not followed in one organisation, which may provide an explanation for the resultant low numbers that eventually accessed the training from that organisation. This experience highlights the importance of continued follow-up and communication between the project team and the host organisations. Consistent effort needs to be put in to keeping dementia awareness training high on the agenda, in an attempt to keep it in the forefront of the minds of health and social care staff.

16.5 Challenges associated with delivering training on site

In anticipation of the challenges of delivering training on site, facilitators discussed the following issues with target organisations with a view to reaching an agreement:

16.5.1 Planning and preparation

As part of the planning and preparation phase, it was agreed that two hours would be allocated to each training session, in order to include all the required components and activities, including a short comfort break. The packages have been designed to be interactive in nature and to engage the participants of the training to engage in some developmental dialogue as evidenced in the findings from the Phase 1.

16.5.2 Proposed location for delivery

Most organisations agreed to host the DAAG facilitators as they delivered the training on their respective organisational properties or sites. Other organisation opted to find a central larger venue that could be accessed by a group of health and social care providers located in a certain geographical location. For example, one CCG found a central location where training could be delivered and then invited people from GP practices, Local Authority organisations and care homes to access the training from that particular location.

Most of the selected training sites were purpose built, with facilities that enhanced teaching and learning for staff working within each organisation. This was especially true of larger organisations such as acute hospital sites and larger GP practices. However, for smaller organisations, venues tended to be smaller and could only accommodate small numbers.

16.5.3 Teaching and learning resources required

The DAAG Tier 1 dementia awareness training package is predominantly an electronic package which was designed using power point with internet links that were embedded into both the Standard and Extended packages. All organisations were asked if they could provide DAAG facilitators with the following teaching and learning resources to use when delivering the Tier 1 training:

- A computer with Microsoft Office Programmes which included Power Point Presentation compatible with Windows XP and/or Windows 97-2003 editions.
- A computer that could play MP3 Videos directly from the internet, videos that were stored on a Compact Disc (CD), DVD or a USB Flash drive Stick.
- Audio Visual Equipment in the form of a wall projector and speakers that could play sounds generated by videos.
- A White Board / Flip Chart Paper / Flip Chart and White Board Pens.
- Computer equipment with internet access.

Facilitators identified that larger organisations were able to provide the appropriate teaching and learning resources. However, some smaller organisations did not have teaching and learning facilities for facilitators to use which meant that facilitators had to take these resources along with them in order to deliver the training. For that reason, during the assessment stage, it was essential for facilitators to identify the teaching and learning resources that were needed.
All facilitators experienced problems with IT equipment failing during the delivery of training. For example, in an acute hospital setting, the Wi-Fi internet connection crashed as the training videos were being shown, which resulted in the use of videos that had been downloaded onto an encrypted USB Stick.

In one GP practice, the Practice Manager confirmed that they had speakers that were loud enough to play the videos. However, on arrival, one facilitator noticed that the speakers were a very small size and the participants could barely hear the sound that was emanating from them. Therefore, the facilitator opted to use the speakers on the computer, which provided a slightly better sound volume and quality.

Some organisations had strict Information Technology (IT) Policies which restricted the use of certain memory sticks that had not been encrypted by the host organisation. In other words, some organisations banned the use of USB sticks and had strong firewalls and ant-virus software to protect the IT Systems from corruption by computer viruses that tend to be spread through the use of USB Sticks. As a compromise, facilitators had to store training materials on a CD or DVD.

In other instances, it was agreed that facilitators would e-mail the power-point presentations in advance of the planned training sessions and host organisations would upload the presentations and open the direct internet links to the dementia videos directly on to their systems. This was a useful strategy that was used to make sure that IT disruption would be kept to a minimum.

16.5.4 Proposed dates for delivery

Facilitators had the task of submitting a list of the agreed or proposed dates and the number of sessions that were being offered. It was agreed that host organisations would find the physical space where the training would be delivered and then acquire that space through various room booking systems. Once the rooms were booked, the host organisations confirmed where the training was going to be held.

Facilitators spent a considerable amount of time organising dates and venues. Confirmation by host organisations sometimes depended on the cancellation of other training events or on the levels of interest shown by their clinical staff. Facilitators kept a record of all confirmed or offered sessions on a central database.

16.5.5 Cancelled sessions

A major issue that facilitators faced was when planned sessions were cancelled or rejected by host organisations. Some of the reasons given were a lack of physical space to host the training, competing demands on staff, some were already delivering their own version of Tier 1 training, hence they felt that they did not require the DAAG Training. One facilitator observed,

‘It was very difficult to get into the CCG which had not adequately advertised the DAAG Training package across its organisations. This may explain the low uptake. I offered them 12 sessions and they only accepted eight sessions, most of these were advertised to local authority care homes and other interested organisations.’

‘At the start of the delivery phase, one community health trust didn’t really think they needed Tier 1 training. However, they started to ask for sessions and this seemed to make up for some of the lost sessions.’

Every effort was made by the project team to offer the training sessions to other organisations who were interested in Tier 1 dementia awareness training within specific locations in the Thames Valley Regions. For example, some of the organisations who had been approached during Phase 1 of the project in the Buckinghamshire area were approached and invited to attend training at appropriate venues.

16.5.6 Poor attendance

At times, some facilitators delivered training to very small numbers. This was because some participants had not been released from practice, but it was not clear why participants had not managed to attend. One facilitator suggested,

> ‘We know that some people did not attend their Tier 1 training, but we did not really explore why people were not coming. Also, even though training was being delivered on the hospital site, without charge, people still did not sign up. Some research needs to be done in order to explore why this was the case. This would certainly help with addressing this issue when planning for future Tier 1 dementia awareness training.’ (Acute Hospital Setting)

16.5.7 Registration of staff to attend the training

The host organisations also agreed to process the registration of staff who would be attending the training. This important work was undertaken by an identified administrator who processed all the bookings on to the training on the proposed dates, after the room bookings had been confirmed.

In order for the delegates to get the most from the training, various host organisations made strategic decisions on the number of people who could attend each training session. In primary care settings, some venues accommodated 30 people, others had as little as 12, whilst some acute hospital trusts agreed to have a maximum number of between 24 and 40 people to attend each session.

The minimum number of people that were required in order for each session to run was five. Each host organisation was issued with a template for the register which would be used to record the names of the people who attended each session.

These names would be added to a live register that was kept by the DAAG as evidence of the number of people who would receive the training over the whole of Phase 2 of the project.

At the end of the delivery day, facilitators would process the registers and scan them to e-mail and then send them back to host organisations, the DAAG Group Record of Attendance and to HEE TV for their records. This would help all to identify who has received the training at Tier 1 Level.

16.5.8 Hospitality and catering

Inviting people to attend face-to-face training meant that some thought was given to the hospitality and catering needs for the participants and facilitators. Facilitators discussed this with host organisations, who then agreed to provide the Tier 1 training facilitators with access to tea and coffee making facilities as well access to the use of a microwave.

For the participants who would be attending the training, some host organisations indicated the existence of nearby coffee shops or vending machines, some being situated right within the building where the training was being delivered. This meant that participants were able to get their own refreshments from such facilities.

Other organisations such as GP practices provided lunch and drinks as part of the training. Facilitators noticed that the provision of lunch and refreshments contributed to an effective teaching and learning environment.

16.5.9 Training material for staff to take away

The project team agreed that training materials would be provided to the staff attending the training. These would take the form of an information pack with some details of the session, and would sign post participants to resources that they could access once they had completed the training. All staff would be issued with a Certificate of Attendance which would be signed and dated by the Tier 1 dementia awareness training Facilitator.

During the delivery of the training sessions on various sites, it was noted that facilitators experienced common difficulties. This included significant issues with equipment not working properly during the sessions; poor attendance by participants; cancelled sessions and the implications of this on the overall project.

Facilitators also reported feeling isolated and alone when delivering training and some felt a lack of confidence at having to deliver training in alien or unfamiliar surroundings. The following section will explore these issues in more detail and it will explore some of the strategies that were used by facilitators in response to these difficulties.

16.5.10 Feeling isolated and alone

The experience of delivering training to multiple audiences proved to be a lonely experience for facilitators. Facilitators found themselves applying the Lone Worker Policy when, in some cases they needed to travel great distances in order to deliver training. The experience of being on the receiving end of powerful and sometimes negative emotions also contributed to feelings of isolation.

16.5.11 Lack of confidence

Facilitators also recorded experiencing a lack of confidence in their own skills, particularly when delivering training during the earlier stages of the delivery of the packages. This was partly due to the newness of delivering a recently developed package to a variety of audiences with mixed expectations about what should be included in Tier 1 dementia awareness training.

Some facilitators reported feeling intimidated at the thought of delivering dementia training to medical doctors, and other very experienced medical professionals who may have significant clinical experience in the care of people with dementia. One facilitator noted feelings of surprise when many GPs were not familiar with the term, “person hood” or with the concept of “person centred care”. This helped to build confidence in their own ability to deliver Tier 1 training to all health and social care staff.

5.5.12 Key lessons learned by facilitators

As described in the section above, it can be seen that a considerable amount of time was spent in the preliminary activities of engaging with host organisations, assessing their Tier 1 dementia awareness training needs as well as planning the dates, times and venues before the training was actually delivered. Some of the lessons learned:

a) Facilitators recognise that time needs to be allocated to the initial phase of preparing to deliver Tier 1 dementia awareness training. Establishing collaborative working relationships with host organisations was crucial to the success of the planning phase of the project.

b) Facilitators acknowledged that they were working with a variety of organisations with competing clinical, political and financial demands. Therefore, having a flexible approach was effective, as this helped facilitators to plan to deliver the training.

c) Facilitators accepted that paying attention to the details with regards to venues, teaching and learning resources, IT policies and the provision of hospitality and catering services was an important part of preparing to deliver Tier 1 dementia awareness training.

d) Facilitators acknowledged that they themselves needed to prepare to deliver Tier 1 training.

The next section will discuss some of the preparatory work undertaken by facilitators before delivering Tier 1 training.

16.6 Preparing the facilitators to deliver Tier 1 training

16.6.1 Opportunity to observe training

As a way of familiarising themselves with the package, facilitators had the opportunity to observe the training being delivered by one of the Phase 2 Project Leads. This was especially useful for the fourth facilitator who joined the team to help out with the delivery of the already developed packages. This process was a way of bringing the facilitators together, to acquaint them with the packages, as well as address any anticipatory concerns or anxieties about the content. Such advanced preparation empowered them to deliver the sessions to identified host organisations.

16.6.2 Essential equipment needed to deliver the training

Although all the preliminary work of setting up training with host organisations had been done, facilitators needed to be prepared to travel some great distances in order to reach the training venues. One facilitator travelled long distances in order to access various training sites located within the geographical location of one CCG.

Some facilitators travelled a round trip of 90 miles in order to deliver the training. Therefore, facilitators had to have access to a good map, satellite navigation, and also a fully charged mobile phone which could be used to contact a host organisation, in order to seek guidance and directions in case they got lost.

16.6.3 Preparing to engage in reflection and reflective practice

In order to capture the lived experience of delivering the Tier 1 training, the project team suggested that all facilitators keep their reflections, reflexive accounts or field notes of their experiences. This formed another important part of the facilitator activities, which would then feed into the evaluation of the effectiveness of the Tier 1 training packages.

In addition to the individual activity of reflective writing, the project team also encouraged facilitators to engage in peer support; in discussing experiences during operational meetings whether in person or in teleconference calls; as well as giving feedback during monthly steering group meetings held with HEE TV.

Having engaged in this extensive preparatory work, the facilitators were ready to deliver the training.

The next section of this report will discuss the lived experience of the facilitator and the impact that this Tier 1 dementia awareness training had on the individuals who received it.

17 Delivery of training – the lived experience

This section reports on what it was like for facilitators to deliver the Tier 1 dementia awareness training, from the time they arrived at the host organisation to the time they evaluated and concluded the training. Comments from facilitators will be included in this section and they will highlight some challenges faced as well as highlight some outstanding experiences. This will be complemented by a discussion of the impact that the training had on the participants who received it.

17.1 Facilitator arrival at training sites

Overall, host organisations gave the DAAG facilitators a warm welcome to their organisation and there was an organisational representative on hand to meet and greet DAAG members on arrival. This really helped to put the facilitators at ease, before they engaged in the setting up of rooms and in the actual delivery of the training.

One facilitator got lost before arriving at the venue and arrived at a GP Surgery where the front door was locked and the side entrance was concealed. However, a Practice Manager was on the lookout and was able to direct facilitator to the right entrance. Such acts of kindness went a long way in helping facilitators to feel welcome.

However, one facilitator stated that she was not always welcomed in some settings. The comment below suggests that despite a lot of preparation, the reality that a facilitator faces may not always match their expectations:

‘As a trainer, travelling to multiple alien sites was an isolated experience for me! I arrived at some GP practices and some GPs were not very welcoming, they did not speak to me and at times I was not offered a drink. Sometimes, I was just directed to an empty room and then expected to get on with things. Personally, I found this very difficult to deal with.’

Such an experience highlights the need for supervision systems to be put into place for facilitators who may be experiencing difficulties during the course of delivering Tier 1 Training.

17.2 The reality of the physical space

On the whole, when facilitators arrived at the venue, they observed that the physical space was suitable to deliver the training. In other words, the room was already set up and ready for training to be delivered. In other situations, the physical space bore no resemblance to the space that has been promised by host organisations, which proved to be a real challenge. This is reflected by the following facilitator comments:

‘I turned up and realised that I was delivering the training in a tiny reception area with limited amounts of space. To make matters worse, the projector that I had with me did not work. I ended up using my laptop screen to show the presentation. It was just as well that the space was tiny; everyone was sitting close enough to be able to see the screen and hear the sound when I was showing the videos. It was a very stressful experience.'

'I was shocked when I arrived at a venue which had promised that they had equipment and yet all they had was a white board! It is just as well that I had my laptop and projector and speakers in my car, I was able to deliver the training in really cramped spaces.'

'I needed to clear the room and set up the tables and chairs in preparation for the training. This took a lot of time before I could deliver the session.'

17.3 Teaching and learning resources: expectations vs. reality

Despite the best laid plans, in some settings, videos did not play even when they uploaded onto a USB stick. Some videos buffered a great deal, at times the images on the screen froze or the video simply did not play at all, which may have affected the learning experience of some of the participants. In such a situation, one facilitator stated:

'When I was delivering training to a GP practice, the video about Living with Dementia" buffered, but the narrative could be heard beautifully. Therefore, I chose to carry on playing the narrative and then apologised for the technical problems as the end of the video presentation. As a compromise, I said that I would send an e-mail link to the contact person for that particular organisation, which would then be sent to all who were in attendance. This was generally well received by the participants and I was able to carry on delivering the training. However, when it came to showing Barbara's Story, I asked the host organisation to help me to access it directly from the internet and this worked really well.'

'Personally, I found it very stressful when IT equipment did not work, especially when I had tested it all before I arrived on site and it had previously worked. There I was in an alien environment and now I had to deal with the stress of IT equipment failing to work. It was really hard and I was exhausted by the end of it all.'

18 Facilitator observations

This section will now report on some of the facilitator observations that were captured by means of their field notes and reflective practice. Comments will include significant observations that were made at the start of the training, during the training and after the training had been delivered. These comments will highlight how Tier 1 dementia awareness training was received by a mixed audience of clinical and non-clinical staff and how that audience intended to use that valuable information and knowledge when working with people with dementia across a variety of organisations.

18.1 Observations at the start of the training

18.1.1 Number of people registered to attend vs. number in the room

During the registration phase, facilitators noted that the number of people that were booked on to a session were not always present to receive the training. In the majority of the sessions, facilitators observed that there were people registered, but they did not attend. This emphasised the long standing problem of releasing staff to attend the training. One facilitator commented:

> ‘Releasing staff was a huge problem across many organisations. Some of the CCGs were unable to release staff and therefore offered the training to local authorities and care homes.’ (Primary Care Setting)

> ‘I had a register with 15 people on the list and only eight of them arrived for the training. In some sessions, only two people turned up to a session that had been registered for eight people.’ (Acute Hospital setting).

Some organisations addressed this problem by making the attendance to the training mandatory. For example, one GP practice had full attendance because the Practice Manager made the attendance compulsory, had blocked all annual leave requests for that day and had planned another Tier 1 dementia awareness training session with a neighbouring GP practice. This worked well for this organisation. However, the facilitator noted that very few participants wanted to be involved in the six week follow-up evaluation of their experience of the training.

According to the session plan, the establishment of boundaries and the setting of ground rules were seen as an effective way of creating an environment that was conducive for delivering emotive content using a face-to-face forum:

> ‘I think that the training packages were designed to address the concept of person centeredness in a sensitive and meaningful way. Having the ground rules and offering to debrief people after the session was a good way of setting the scene for what was to follow.’ (Acute Hospital Setting)

18.1.2 Low levels of expectation at the start of dementia training

One facilitator observed that some participants had arrived to the Tier 1 dementia awareness training expecting it to be a quick in and out training that was going to be very boring. Therefore, the preliminary setting of ground rules and talking about the emotive nature of the subject did not necessarily register with some participants, until the session was in full flow:

‘A group of dentists didn’t really see the need to receive Tier 1 training. They didn’t see the relevance to what they did in their everyday practice. Yet when the session started, some of them began to think differently.’ (Community Hospital Setting)

18.1.3 Changes in viewpoint once the training had started

Once the sessions had been set up, facilitator feedback suggested that there were high levels of staff engagement. The following comments highlight this:

‘The ‘Forget Me Not’ Campaign was a good starting point for participants. Although some did not always know what to say, as they had never really thought about seeing themselves in a position when they may be unable to speak for themselves, it certainly opened up their minds to what it may be like for people with dementia, who may be in that situation.’ (Acute Hospital setting)

‘Once the session aims were presented, staff did engage well with the training. Training in GP practices was well received mainly due to smaller groups due to staff numbers and the size of rooms available.’ (Primary Care setting)

‘The ‘Forget me Not” campaign promoted self-disclosure. It was unique for a GP to self-disclose what it was like to have a parent with dementia. It promoted open and honest communication in the audience.’ (Primary Care setting)

18.2 Observations during the training

18.2.1 The effects of mixing clinical and non-clinical staff

The inclusion of the activity that explored participants’ perceptions about dementia was a significant trigger point for a meaningful discussion. This allowed for inter-professional learning to take place between clinical and non-clinical staff, whilst including novice participants who may not necessarily have had personal or professional exposure to a person with dementia. Therefore this mode of delivery was greatly appreciated by participants.

Facilitators noted that the face-to-face element and the use of experiential learning strategies which utilised pair work and group work was very effective. Participant generated scenarios and real life experiences from those present were used to promote reflective thinking in a productive way:

‘Mixing clinical and non-clinical staff was very effective, it really relaxed and engaged the audience and somehow served to flatten the hierarchy and approached everyone at the same level.’ (Acute Hospital setting).

‘I noticed that there was a fear of being tested or asked to participate in role play especially for people in supporting roles such as housekeeping.’ (Care Home setting)

‘A highlight for me was the multi-disciplinary approach to training, which was emotive, interactive and encouraged some simulation.’ (Acute Hospital setting)

‘People responded well to the slide which showed some examples of famous and not so famous people with dementia. There were some participants who were surprised at seeing some of the faces of famous people who have dementia.’ (GP practice setting)

‘The training prompted disclosure about personal experiences of dementia in three categories: past, current and anticipated experience.’ (Acute Hospital Trust)

Although the Tier 1 dementia awareness training was designed to reduce isolation by providing a forum where people could have a developmental dialogue about dementia, facilitators noticed that there were some individuals who self-isolated from the actual sessions once they had started. For example, some GPs in a GP practice setting attended the first part of a training session, but did not return after the break. Other GPs sat through the training, but were reluctant to speak about their experiences of working with dementia.

Some non-clinical staff complained about having to attend the training session. A Practice Manager reported that a non-clinical staff member stated that they should not have attended Tier 1 training because it really upset them:

‘No-one can tell me about dementia! I know all there is to know about dementia because I am looking after my mum!! I don’t need anyone to tell me that!!’

While these are a relatively small number of experiences, it is important to note that this was their reality at the time of the training and also to acknowledge that one size training package does not fit all. It is also important to acknowledge the sense of isolation that comes from recognising that, in some cases, there is nothing friendly about dementia. The reality for many is that dementia is a debilitating and difficult condition to live with which can be quite isolating. The following comments illustrate this:

‘My daughter used to work as a care assistant and she was attacked by an aggressive person who had dementia. It was terrible for her. She had terrible injuries and she had to quit her job. Dementia can really affect people. I wish that I had had this training then.’ (Domestic Manager, Acute Hospital)

‘My mum was diagnosed with senile dementia at the age of 65 and she dies at the age of 69. That was tragic.’ (Receptionist, GP practice)

‘I do not have anything good to say about dementia. My granddad had terrible dementia, he was sectioned under the 1983 Mental Health Act because he got violent! That was terrible!’ (Health Care Assistant, GP surgery)

‘My mum has dementia and she has an imaginary boyfriend. This is a shock for me! I think it is terrible that she betrayed the memory of my dad, who was loyal to her! So I prefer to keep the memories of the mum that I had before.’ (Administrator, Acute Hospital Trust)

The difference for those who did access and engage with the training seemed to suggest that their awareness had been raised and they learned about the practical and person centred approaches that they could implement almost immediately after the Tier 1 training session was finished. In other words, the training appeared to have had a significant impact on those who attended it. It helped them to see that they were not alone in their experience and helped them to know how to access resources that facilitators were able to signpost them to.

187.2.2 The impact of videos on participants

In their feedback, facilitators noted that the videos had a significant impact on the participants who saw them. This impact was felt after each video was shown, as supported by the following comment:

‘The use of the videos from the Social Care Institute for Excellence (SCIE) was very good. It helped to connect people. It showed that people can have this condition called dementia but experience it very differently.’ (Care Home Setting)

For some participants, it was difficult to hold back the tears. Therefore, facilitators invested in packets of pocket size tissues that were discreetly placed on tables, ready for when they were needed:

‘In most sessions, the videos evoked emotion and connection. The theme music in Barbara’s Story was very powerful, it really cut to the core of participant’s hearts and it reduced many to tears. After this happened during the first session that I had facilitated, I ended up buying small packets of tissues to give to participants who began to cry during the sessions.' (Primary Care Setting)

It was also observed that participants were not always able to engage in a verbal discussion about what they had seen on the videos. Some needed time to compose themselves emotionally, in order to articulate their thoughts and feelings about what they had seen.

Others just sat in stunned silence and were visibly moved by what they had seen. This meant that facilitators needed to give participants the time and space to process and begin to make sense of the visual images and stories that they had just seen and heard. One facilitator engaged in an ontological discussion with a GP trainer about the stunned silence in the audience after each video was shown, and what that might mean. This discussion is captured in the following excerpt:

'A GP approached me at the end of the training and commented on the emotive nature of Barbara's Story and its visible impact on the audience. This GP, who is also a trainer, said that when you are taught how to teach, you are encouraged to seek verbal feedback from the audience. In a sense, that is what you grow to expect. However, in the instance, after showing Barbara's Story, there is very little verbal feedback but there is a great deal non-verbal feedback which you as the facilitator can feel as it is projected in the room. In your audience, the stunned silence is the feedback; accompanied by the soft sobbing, the rustling of tissues and the blowing of running noses. That is when you know that the training has done its job. It has raised awareness about what dementia really is and how it really and truly affects people. That is the significance and the meaning of the stunned silence that you as the facilitator hears and experiences after the delivery of each and every video.'

The presence of participants who were looking after a loved with dementia and were disgruntled by the lack of services provided by health and social care organisation proved to be a challenge for facilitators. This was especially difficult if the participants chose to self-disclose during the session and then proceed to express their anger and frustrations towards the facilitator.

It then became a real challenge to pacify an angry and sometimes aggressive participant, who was misdirecting their anger at the facilitator and then distracting the audience from the training. This called for facilitators to develop de-escalation skills which dignified the disgruntled participant whilst steering the focus of the discussion back to the content of the training. This is reflected in the following comments:

'Those with relatives with it (dementia) struggled to sit through the training. Some walked out before the training was finished, because it was too close to home for them.' (Care Home Setting)

‘One woman was very angry during the session. She shouted, “Why does the person with dementia have to sell their house, when the person with cancer gets help from the state?” The GPs are not interested! No-one helps my mum!! We all live far away!! I’m feeling guilty!! How is this training supposed to help me?” This lady was just venting her frustrations, but it was clearly not the appropriate forum in which to do so. I found it really hard to help this woman to calm down as whilst I was trying to meet the training needs of everyone else in the audience. In the end I offered to have a 1-1 conversation after the training was finished. This seemed to work.’ (Acute Hospital Setting)

The facilitators all agreed that at times it was a real challenge to manage the strong emotional impact of the content on participants, despite the fact that exactly the same content was having an emotional impact on the facilitators themselves.

Coming face-to-face with angry, disgruntled and emotionally exhausted people who were or had lived with a person with dementia was difficult and emotionally taxing on the facilitators themselves. In certain situations, facilitators provided a listening ear and kindly signposted distressed people to appropriate resources. It was noted that Barbara’s story evoked mixed and sometimes very negative emotions within the audience. The comments below illustrate this:

‘The use of Barbara’s Story was very good. In some care homes, some of the staff who work in these care home settings have the most contact with people with dementia yet they tended to have the lowest levels of training. In some cases, care home staff spoke very little English. They were able to give high quality care and they responded particularly well to Barbara’s Story. The emotive element of Barbara’s distress seemed to transcend language barriers.’ (Care Home Setting)

‘I noticed that some participants were angry with Barbara’s daughter. They often asked, ‘Why wasn’t the daughter there? Why didn’t she visit her mum more?’ Other participants criticised the in-patient services, which were portrayed as failing Barbara, particularly when she fell over in the Accident and Emergency (A&E) Department and she was discharged home, without proper support. I had to fill in the gaps and let the participants know that Barbara’s daughter actually lived in France, which explains her apparent absence. This then sparked an important discussion about societal expectations on informal carers, who are traditionally expected to care for their loved ones with dementia, regardless of their own personal circumstances.’ (GP practice Setting)

‘Barbara’s story won hearts first and then the minds of the participants who watched the film.’

18.2.3 Impact of Risk Factors for Dementia

All facilitators noticed that the content in the training that addressed the risk factors for dementia and diagnosis tended to generate a lot of discussion amongst the participants:

‘I noticed that risk factors of dementia promoted a lively debate!’ (Primary Care Settings)

‘Some participants questioned the benefits of exploring the risk factors, then focusing on increased diagnosis when the post diagnosis support for people with dementia is very limited. What was the point of that?’ (Primary Care Setting)

‘There was some misunderstanding as to how dementia is diagnosed. For example via a blood test, a dementia test at the GP surgery using the Mini Mental State Exam (MMSE).’ (Care Home Setting)

18.3 Observations after the training

The following comments reflect the overall comments that facilitators captured after they had finished delivering the training:

‘The person centred focus promoting compassions and dignity was well received by all the participants. A significant number of participants reported a greater understanding of relatives with dementia.’

‘The dementia apps were well received. One GP got his phone out and he immediately started to download all the dementia apps onto his iPhone. He was very excited at the prospect of sharing these with others.’ (Primary Care Setting)

‘Some participants requested Tier 2 dementia training.’ (Acute Hospital & Primary Care Settings)

‘Sign posting was crucial. Some participants were very interested in knowing more about dementia on both a personal and a professional level.’

‘GPs frequently asked questions about diagnosis and how to manage the relatives’ expectations after their loved one is diagnosed with dementia. They wanted to know how to seek consent from the person with dementia to share sensitive information with relatives. There were questions about medication used to slow dementia down and how to respond appropriately to relatives’ questions about efficacy. If there is no improvement in their loved one’s dementia, what happens next? GP stated that they were not familiar with anticholinesterase inhibitors and their management after prescription….contrary to the perception that GPs will know all about Aricept.’

‘Other GPs were concerned about how to manage the false hope that relatives come with once medication such as Aricept has been prescribed.’

‘I noticed that some GPs wanted to know how to rectify relatives’ misunderstanding of the assessment process. Some relatives thought there was a dementia test versus a memory assessment. Some GPs felt awkward about using the word dementia as part of the assessment process.’

18.4 Observations during the evaluation of the training

‘I observed that some support staff were more likely to mark their pre-training knowledge as good. Potentially the four stages of competence (unconscious incompetence/ conscious incompetence/ conscious competence and unconscious competence). Some marked their pre-training knowledge as good, although the question that they asked during the session would suggest otherwise. GPs and registered nurses were more critical of the pre-training knowledge.’ (Primary Care Setting)

‘I observed that many participants stated that this Tier 1 dementia awareness training should be made available to everyone. The participants who attended the sessions with low numbers stated that they were going to use word of mouth to spread the word about the dementia training!’ (Acute Hospital Trust)

‘Although some organisations stated that 2 hours was too long for the sessions, it was interesting to notice that many participants were willing to linger and talk after the training session had ended.’ (Acute Hospital Setting)

‘All participants gladly accepted their information, certificate of attendance and their Dementia Friends Badges. It appeared that these items were a reward and also recognition of their attendance of the DAAG Training.’ (All settings)

19 The impact of training on the participants

The responses from the participants who received Tier 1 dementia awareness training confirm that dementia training at this level remains a priority. The facilitators delivered training to over 1,400 participants and it was interesting to see how many health and social care staff had never received basic awareness training. Even some very experienced practitioners commented that they had learned something new after receiving the Tier 1 training.

This section reports on some of the comments that highlight the impact that the training had on the participants who received it. It includes with comments that demonstrate how the training raised awareness, reduced stigma, reduced isolation and promoted the development of dementia friendly communities which are better able to care for people with dementia and their carers.

19.1 Immediate evaluation during and after the training

The benefits of face-to-face training in preference to e-learning were mentioned by many participants. Face-to-face training was preferred because it provided people with an opportunity to have developmental conversations.

‘With online learning, you can just click your way through the activities until you get the right answer. It does not mean that you have learned anything. It just ticks a box. I like having the chance to talk about this really important subject.’ (Nurse, Acute Hospital Trust)

‘This training was much better than I expected.’ (GP practice Staff)

‘I learned more than what I expected to learn. Personhood is so important. It has made me think of some of the nursing homes that I visit, the ones that feel homely and comfortable. I now understand why they are like that, they are being person centred.’ (GP, Medical Centre)

The concept of living well with dementia was new to some participants and the focus of the packages on person centeredness, promoting compassion and dignity were very well received. The Social Care Institute of Excellence Videos were seen as a really good resource for challenging perceptions about the person with dementia. Hearing the answer to the question: “What does it feel like to live with dementia?” as portrayed in the video (Social Care Institute for Excellence, 2014) was received as an excellent resource that gives an insider perspective about life from the viewpoint of the person with dementia.

‘It is important for people to remember that the person with dementia was once somebody who did a job, raised children, ran businesses.’ (Healthcare assistant, Hospital)

‘This training package has really got the power to highlight the emotional impact of dementia on people!’ (GP, Medical Practice)

‘I was interested in hearing directly from the person with dementia. I felt that the “Living with Dementia” video had a real impact on me.’ (Staff Nurse, Acute Hospital Trust)

‘End stage dementia is all we see. We don’t see them (person with dementia) when they are well.’ (Healthcare Assistant, Acute Hospital Trust)

This training challenged some misconceptions that some clinical staff had about people with dementia.

‘I am going to stop making the assumption that people with dementia are unhappy.’ (Practice Nurse, GP Surgery)

‘I didn’t realise that people with dementia still had a strong sense of identity.’ (GP, Medical Centre.)

‘I had no idea that there was such a thing as mixed dementia.’ (GP, GP Surgery)

Contrary to the opinion that some content may not be applicable to non-clinical staff, it was interesting to note that non-clinical staff expressed an interest in knowing more about dementia.

19.2 Immediate experience of training and how it made participants feel

There were some hidden dementia carers in the audience, who experienced real shock and surprise when they came to realise that they had been living with someone who had dementia and they had not been aware of it. In this discussion, some cultural aspects and perspectives also came to the fore, as indicated by the comments below:

‘Oh my goodness, my friend had CJD!! I didn’t know that was a type of dementia!’ (Administrator)

‘My grandmother in Nigeria has dementia and she was accused of witchcraft because she could see things….when all she was seeing was a hallucination!’ (Non-Clinical Staff)

‘This session helped me to understand the strange behaviour of my grandmother when I was young.’ (Polish Hospital Porter)

‘As a GP, this training session really reminded me of the emotional impact of dementia on the patient and those around them! To see the person behind the condition.’ (GP, GP Surgery).

Many participants disclosed personal experiences of caring for someone with dementia and reported a greater understanding of relatives with dementia:

‘My grandmother…she had that look…like the one Barbara had in the story where she did not recognise her daughter…I remember that look...’ (GP, Medical Practice)

‘“Barbara’s Story” triggered strong emotional responses which won hearts and minds of many participants. Some were quite critical and related it to their own clinical practice.’

‘We see how dementia affects family and relatives.’ (Outpatient nurse, Acute Hospital Trust)

‘It’s a nightmare this video! No-one’s introduced themselves!! She had a fall because of them!! I see this all the time.’ (Health Care Assistant, A&E Department, Acute Hospital Trust)

‘This is the government’s spin on dementia. I’ve seen people get worse than what’s portrayed in this video!’ (Librarian ~ who gave her critical commentary all the way through Barbara’s story)

‘I got to feel about dementia as it affects how you care.’ (Care Home Carer)

‘I was hoping that Barbara’s symptoms were indicative of cancer…not dementia! I was disappointed that it was dementia!’ (Receptionist, GP practice)

The content of the package motivated and enabled many participants to think about changing what they do in their daily practice:

‘I am going to improve the signage in my GP practice, not only to help people with dementia, but also people with Autism, visual impairment, learning disability and other limitations.’ (Practice Manager, GP Surgery)

Dementia risk factors raised self-awareness, insight, and promoted lively debate among the participants:

‘I am just sitting here and thinking that I’m a high risk of developing dementia. You could remove the word “dementia”…those are risk factors for stroke, heart disease & diabetes.’ (Nurse, Acute Hospital Trust)

‘This is preparing me for how to care for my mum.’ (Receptionist, GP practice)

19.3 Evaluation forms

Facilitators had the important role of supporting the evaluation process by initiating the data collection process. All participants were invited to participate in the evaluation phase immediately after the training session through the completion of an evaluation form. They could also indicate if they had any interest in participating in a follow up online evaluation and a telephone interview. At the conclusion of each session, evaluation forms were collected from participants and processed for analysis as stated in the Phase 3 project aims.

Facilitators had to provide a clear explanation of how the forms were to be completed and what would happen with that information. Findings from the analysis of these evaluation forms will be presented in the Phase 3 report.

20 Evaluation of phase 2 delivery

This section presents the overall evaluation of Phase 2 Tier 1 training delivery. Feedback was provided to stakeholders at an event that was held in January 2016 and key themes from that event will be presented below:

20.1 Stakeholder Event

After the project had been running for 18 months, the DAAG project team in partnership with HEE TV commissioners hosted a Stakeholder Event on Tuesday 12th January 2016. The purpose of this event was to provide a Tier 1 dementia awareness update to Dementia Champions and various stakeholders (representatives from HEE TV; Oxford Health; primary care; end of life care and Buckinghamshire Health) within the Thames Valley region.

Attendees were informed that the DAAG was preparing for the final stages of the project, which would involve the handing over of the project in a manner that ensures sustainability and its future use. Stakeholders and dementia champions were invited to meet the project team; were given an overview of the project time frame; reacquainted with the projects aim and objectives; received an explanation of the project design and were invited to participate in a developmental conversation about the sustainability of the Tier 1 dementia training programme.

20.2 DAAG training packages - a good product?

A presentation of the training packages was delivered to the stakeholders who were present at the stakeholder event. There was a general agreement that nothing needed to be taken out of the training package. Face-to-face contact was seen as an effective method of supporting the human element of working with people with dementia.

Comparisons were made with other types of training packages such as “Sage and Thyme” communication training, which works with multi-disciplinary groups, and the idea of doing a train the trainer model was welcomed. It was agreed that the trainer would need to be able to manage any people who may be in distress as a result of talking about dementia or disclosing their personal experience of caring for a relative or close friend who has dementia.
The mixing of clinical and non-clinical staff was well received because it provided more opportunities for meaningful interaction among the participants in the training.

The concept of person centeredness was embraced and generally well received. The use of the VERA framework was seen as appropriate for Tier 1 dementia awareness training. There was some discussion about looking at dementia as a thread that runs through and feeds into other themes. For example, the content could link in the following ways: dementia and frailty; the assessment and management of pain for people with dementia; wound care for the person with dementia; person centred care and dementia; dementia care and long term conditions; dementia care and end of life care.

20.3 Changes required

The following sustainability issues were raised by stakeholders. It was suggested that the training needs to be embedded strategically within organisations and must meet a real need that the workforce presented with. Connecting training with workforce analysis would be helpful to provide a case for the need for training – what are the needs of the staff/practice? How are these linked to the needs to the community?

There was a preference for face-to-face training, however there are resource issues for this and therefore, it should be acknowledged that online delivery can serve a purpose on occasions. It was suggested that the training must be linked to supervision and Continuing Professional Development (CPD) activities to ensure engagement and support embedding the training in the future. A free option was seen as the only sustainable one.

There was a discussion around some of the changes that could be made to the content of the Tier 1 dementia awareness packages. As a start, the length of the session would remain at two hours as standard. However, in order to meet the time constraints of some organisations who can only deliver session in 30 minutes or one hour slots, the content of the package could be broken down into bite size segments that can be delivered in less time; and then this could be supported by signposting participants to other resources. This was welcomed as a possible option that could be considered during the last phases of the DAAG project.

Within the two hour session, it was suggested that some content, such as the political pledges, could be removed with a view to creating more time and space for people to interact. Consideration was given to including more information on diagnosis, and the tools and processes involved. It was suggested that more explicit information could be given about the correlation between dementia, delirium and depression (3 Ds of dementia).

It was proposed that more information about assistive technology such as the use of telecare, global positing systems, and apps could be added. Others suggested that the content could also include Motivational Interviewing as an intervention that can be used when communicating with the person with dementia and their carers.

With regards to the use of video resources, comments were made about using a variety of versions of Barbara’s Story that is more applicable to the setting where the training would be delivered. Suggestions included the use of other stories about Barbara, which include, “The Appointment”, a film that shows Barbara going to an appointment at the dentist.

There were also suggestions made with regards to making the videos more inclusive to people who are hearing impaired by adding subtitles to support the video and audio presentations. The suggestions from this event will be incorporated in the further work of developing a trainer the trainer model as well as the work of finalising the packages that the DAAG will be undertaking during the final phase of the project.

21 Phase 2 conclusions

This section of the report has reported on the findings from Phase 2 of the project. The aim of this phase was to develop and deliver a sustainable model of Tier 1 training across the Thames Valley Region.

The DAAG has developed evidence based and quality assured training based on recognised national standards such as Skill for Health Dementia Training Standards (2015). The content training packages which have been developed have built on the key findings from Phase 1 of the project, together with being mapped against the core skills identified and has delivered face-to-face to an inter-professional audience, which included clinical and non-clinical staff.

Over 1,400 health and social care staff were trained by a total of four facilitators and this report has captured some of the lived experiences from the perspectives of both the facilitators and those who attended the training.

Challenges that were faced, including the cost of releasing staff and also meeting organisational needs have been highlighted and suggestions for the future sustainability of this training have also been identified, which together with the findings from Phase 3 of the project, will form the conclusions and recommendations at the end of this report.

22 Phase 3: Evaluation of Tier 1 dementia awareness training packages

22.1 Introduction

The National Dementia Strategy (2009) highlights three key areas of focus: improved awareness, earlier diagnosis and intervention and a higher quality of care for people living with dementia. All members of the healthcare workforce have contact with people with dementia and/or their carers, either through their role as providers of clinical care or in clinical or non-clinical support roles and there is a need for the healthcare workforce to have an increased awareness and understanding of the needs of people living with dementia and those of their carers (SfH, EE & SfC, 2015).

The HEE original mandate aimed to train 100,000 NHS (England) staff in Dementia Awareness (Tier 1) by the end of March 2014; this mandate was update in November 2013 when the number of staff was increased to 250,000 by the end of March 2015 with the ambition to have every NHS staff member dementia trained by 2018 (HEE, 2014). The Talent for Care Strategy (HEE, 2014) indicated that staff on bands 1-4 makeup 40% of the NHS workforce and are responsible for an estimated 60% of direct patient contact. In addition, the revised mandate identified that greater support for GP training was needed.

The Dementia Academic Action Group (DAAG) was commissioned by HEE Thames Valley to undertake a three-phase project to scope existing Tier 1 dementia awareness training (Phase 1); design and deliver a training package based on the outcome of the scoping exercise (Phase 2); and evaluate the training programme (Phase 3). This report describes the outcomes of the Phase 2 design and delivery in relation to participant learning and is based on self-reported perceptions of the usefulness of programme content and its application in the workplace.

22.1.1 Approaches to educational evaluation

Kirkpatrick (1976) is the most commonly used model to evaluate training programmes (Kraiger, 1993). The model is structured around four levels: reaction, learning, behaviour and results. Reaction focuses on the participants enjoyment of a learning event; learning relates to the extent participants feel they have absorbed the information taught on the course; behaviour refers to the transfer of knowledge to practice; and results refers to the impact of training on achieving organisational objectives (Kirkpatrick, 1976). The model is not without its critics as it lacks detail on psychological learning theory and presumes that learning is a linear process and in some cases that learning occurs at a superficial level (Beech and Leather, 2005). Warr, Bird and Rackham (1970) CIRO model has similarities to Kirkpatrick's but focuses on identifying the state of knowledge and skills before and after training and also evaluates four levels of learning: context, input, reaction and outcome. Context refers to identifying training needs and learning outcomes relevant to the operational situation in which the training occurs. Input relates to the content of the training; reaction evaluates learner enjoyment, similar to Kirkpatrick's reaction level. Outcome is divided into three sub-levels: immediate changes to knowledge, skills and attitude development at the end of the training activity; intermediate changes related to application and changes in on-the-job performance; and ultimate or desired changes in the workforce across an organization.

In order to ensure that the evaluation of the DAAG standard and extended programme could be compare to other similar programmes across HEE, the London Strategic Clinical Network Tier 1 Participant Feedback questionnaire (2014) was reviewed. Following the review of evaluation data collected by one NHS Trust in the HEE Thames Valley, this framework was adopted as a suitable instrument to measure the knowledge and attitudes (affect) aspect of the training.

22.1.2 Aims of the evaluation

The evaluation aimed to provide participants' feedback on the feasibility, applicability and usefulness of the programme from the perspective of participants immediately following the training activity, and again at six weeks.

23 Method

23.1 Data collection

Data was collected for the time period of active training delivery (May 2015- Jan 2016) to facilitate the following metrics:

1. The numbers of training sessions offered (Phase 2 report)
2. The number of training sessions delivered (Phase 2 report)
3. The numbers of staff attending sessions (Phase 2 report)
4. Participant’s self-reported measures of their knowledge, attitude and confidence in caring for people living with dementia and their carers.
5. Participants’ self-reported changes to practice as a result of attending training.

Evaluation data were collected via the application of a pre and post training validated questionnaire using a Likert-type scale which analysed of participants’ self-reported changes in knowledge, attitude and confidence in working with people with dementia (Appendix 12). A further post-training questionnaire was sent six weeks following the initial training to evaluate participants’ application of learning in the workplace (Appendix 13). This included the identification of participants’ perceptions of organisational barriers and facilitators. The Likert scale is an ordinal psychometric measurement of attitudes, beliefs and opinions (Likert, 1932), which is commonly used in educational evaluation. Each item in the scale presents the respondent with a statement with which they can agree or disagree to a greater or lesser extent. The major advantages of the Likert Scale are its broad adoption as a survey strategy and its ease of use, which in addition to positive and negative responses allows participants to indicate that they neither agree nor disagree with a statement. However there are also disadvantages in its use; in particular the fact that five to seven options do not allow for the true attitudes of respondents to be measured. In addition, responses may be influenced by answers to previous questions or by social norms that result in avoidance of the extremes of the item. There is also some evidence that individuals may concentrate their response to items on one side of the scale.

In addition, telephone interviews were conducted with participants who expressed a willingness to participate further in the evaluation to examine if there was anything that should have added or omitted from the training content (Appendix 14). The telephone interviews explored individual and organisational barriers and facilitators in transferring training to practice. Each participating university was scheduled to undertake up to 16 telephone interviews to include eight clinical and eight non-clinical participants. Each interview was scheduled to last approximately 15 minutes on advice from colleagues within NHS Trusts. Interviews were digitally recorded to enable reporting of verbatim comments from participants. In order to limit bias, the interviews were not conducted by the person who had delivered the training event.

23.2 Data analysis

Quantitative data from the questionnaires were cleaned and double entered into SPSS (version 23) for analysis. Two key outcome measures were defined as participants’ knowledge about dementia before and after the training and participants’ changes in attitude, skills and confidence in working with people with dementia as a result of the training. Frequencies were calculated for all measures; clinical/ non-clinical staff who did or did not have contact with people with dementia and employing organisations were cross-tabulated with knowledge, skills and attitude items. Parametric tests were used to perform analyses on responses measured by Likert scale (Sullivan & Artino, 2013); independent t-test, chi-square test for independence and one-way ANOVA were used to assess statistical significance among variables.

Qualitative data obtained via the evaluation questionnaire and semi-structured telephone interviews was analysed using predetermined thematic analysis.

23.3 Ethical issues

The University of West London, College of Nursing Midwifery and Healthcare Research Ethics Committee approved the evaluation phase of the DAAG project. In addition, each partner university submitted the UWL documentation internally for governance purposes.

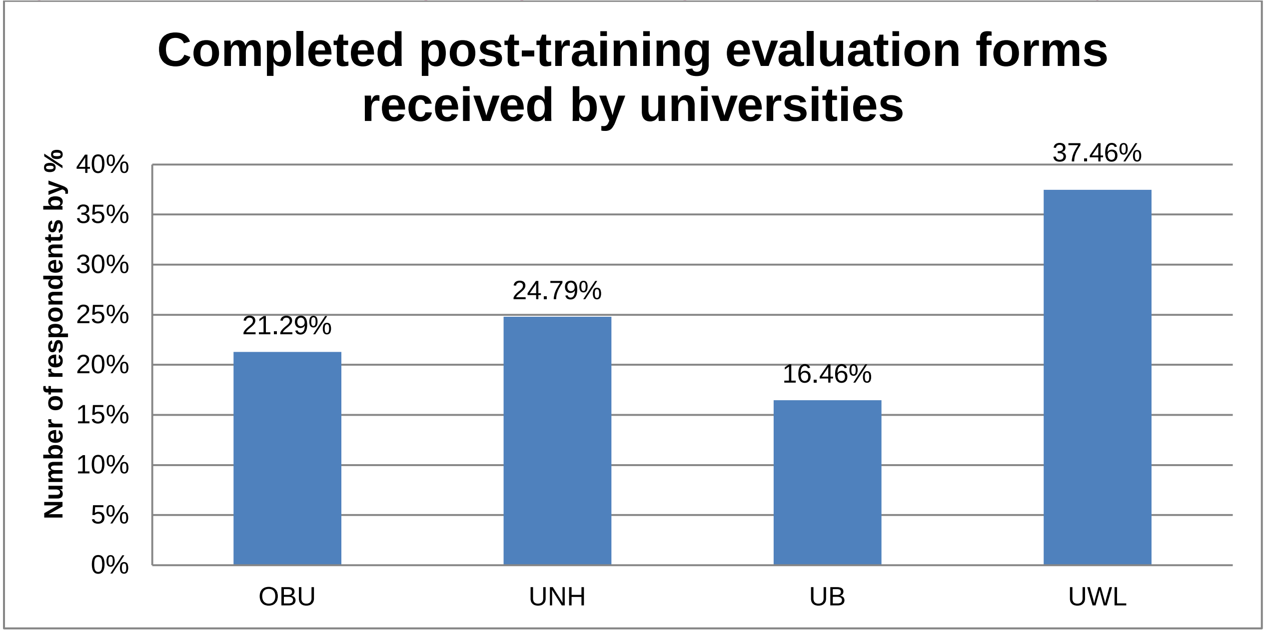
24 Results

24.1 Immediate evaluation

24.1.1 Descriptive

A total of 1057 post-training evaluation forms were received from the four universities involved in the Tier 1 Dementia Awareness Training. Most responses were received from University of West London (UWL), with 396 completed forms returned. Two hundred and sixty two responses were received from University of Northampton (UNH), 225 responses were received from Oxford Brookes University (OBU) and 174 responses were received from University of Bedfordshire (UB) (Figure 33).

Figure 33: Breakdown of completed post-training evaluation forms received by universities



Some participants were excluded from the evaluation phase as they either did not complete the evaluation form or did not receive the full training package. Number of responses received and response rate for the descriptive measures are displayed in Table 17. Missing values on measures were excluded from the relevant analyses.

Table 17: Number of responses received and response rate for each descriptive measures

Items	Number of responses received (No.)	Response Rate (%)
Job titles	1019	96.4
Clinical or non-clinical roles	1017	96.2
Types of employing organisations	1006	95.2
Regular contact with people with dementia	1001	94.7
Face-to-face contact with patients/clients	1027	97.2
Received any previous dementia training	1033	97.7

Breakdown of professional titles and roles

Participants' job titles were classified using the HEE guidance on reporting professional titles. Within the 'Support to Clinical Staff' job category, participants were further divided into two groups: 'Support to Clinical Staff – Healthcare Assistant (HCA)' and 'Support to Clinical Staff – Others'. This was to separate staff who provide clinical or non-clinical support to clinical staff within their job role.

Out of the 1019 responses, the largest job category of staff is 'Support to Clinical Staff – Others', with a total of 269 participants. This category includes participants working as domestic assistants, receptionists, ward clerks, etc. The second largest job category is 'Support to Clinical Staff – HCA', with a total of 234 participants; this includes participants working as healthcare assistants, support worker and activity coordinator, etc. The smallest job category is 'Qualified Ambulance Staff', with only 16 participants. A breakdown of the participants in different job categories is displayed in Table 18 and Figure 34. In addition, more than half of the participants (n = 548, 53.9%) reported to have a clinical role (Figure 35).

Table 18: Breakdown of job role by HEE guidance on reporting professional titles

Professional Categories	No.
Medical and Dental	42
Registered Nurses	190
Scientific, Therapeutic and Technical	83
Registered Ambulance Staff	16
Support to Clinical Staff – Healthcare Assistant (HCA)	234
Support to Clinical Staff – Others	269
Infrastructure Support	144
Others	41

Figure 34: Breakdown of professional categories by percentage

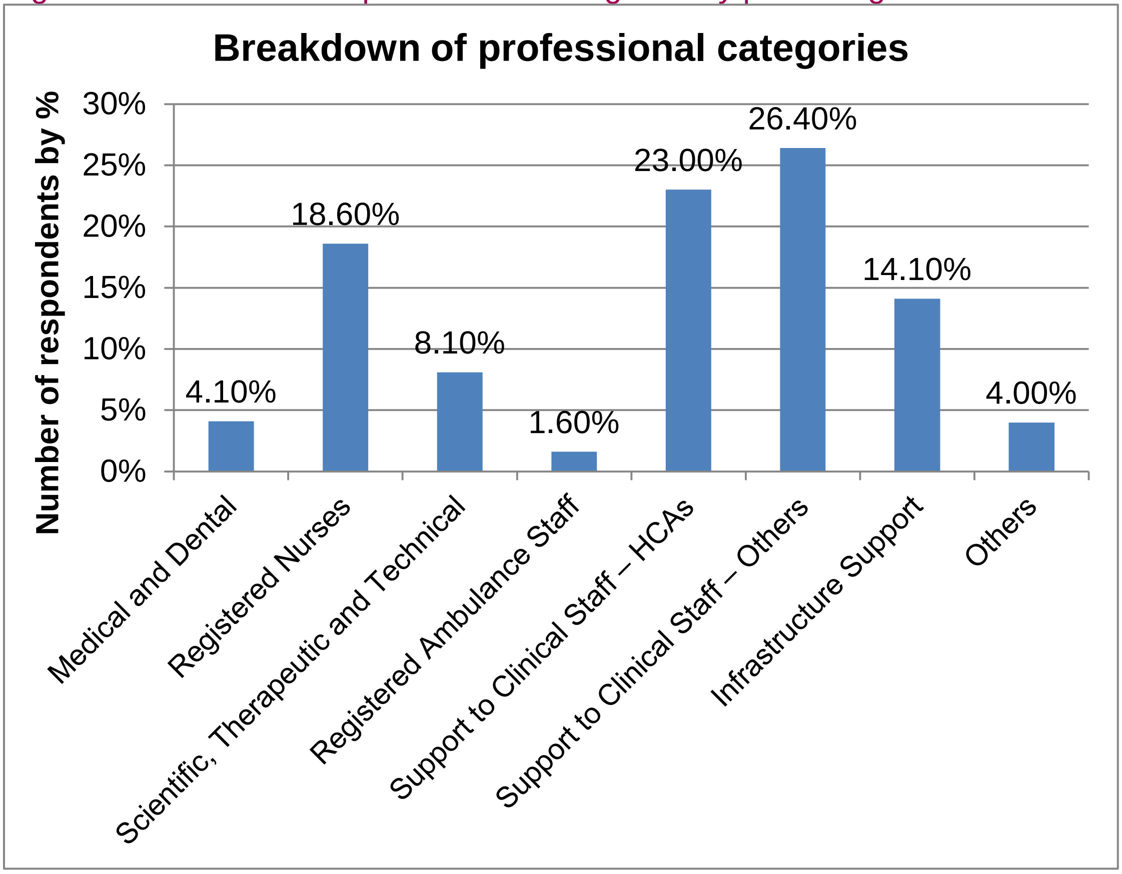
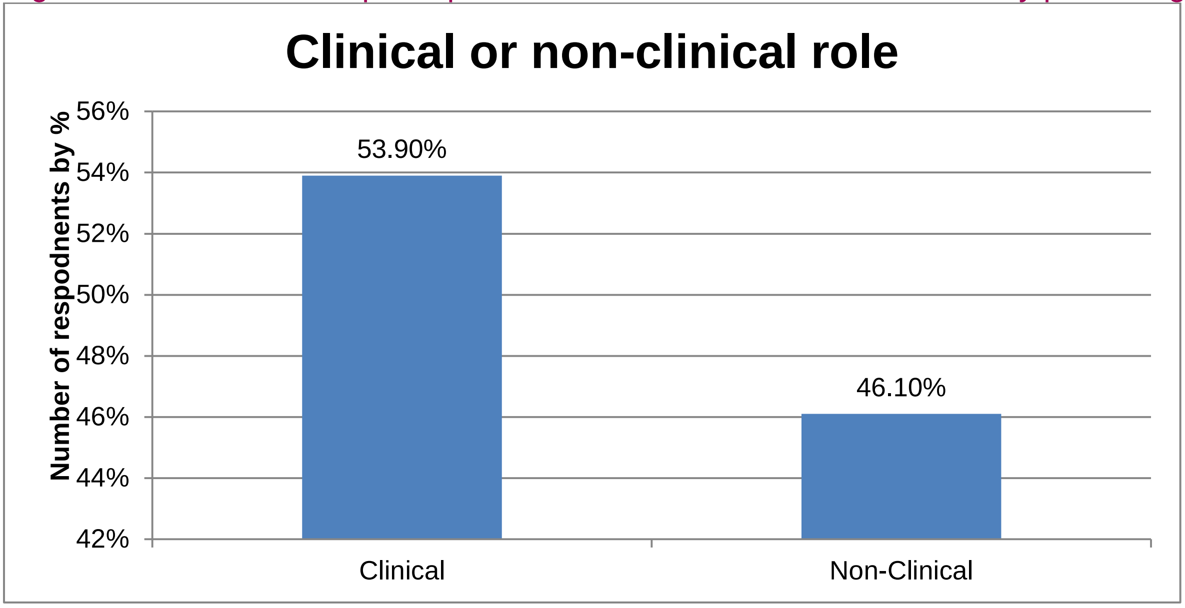


Figure 35: Breakdown of participants with a clinical or non-clinical role by percentage



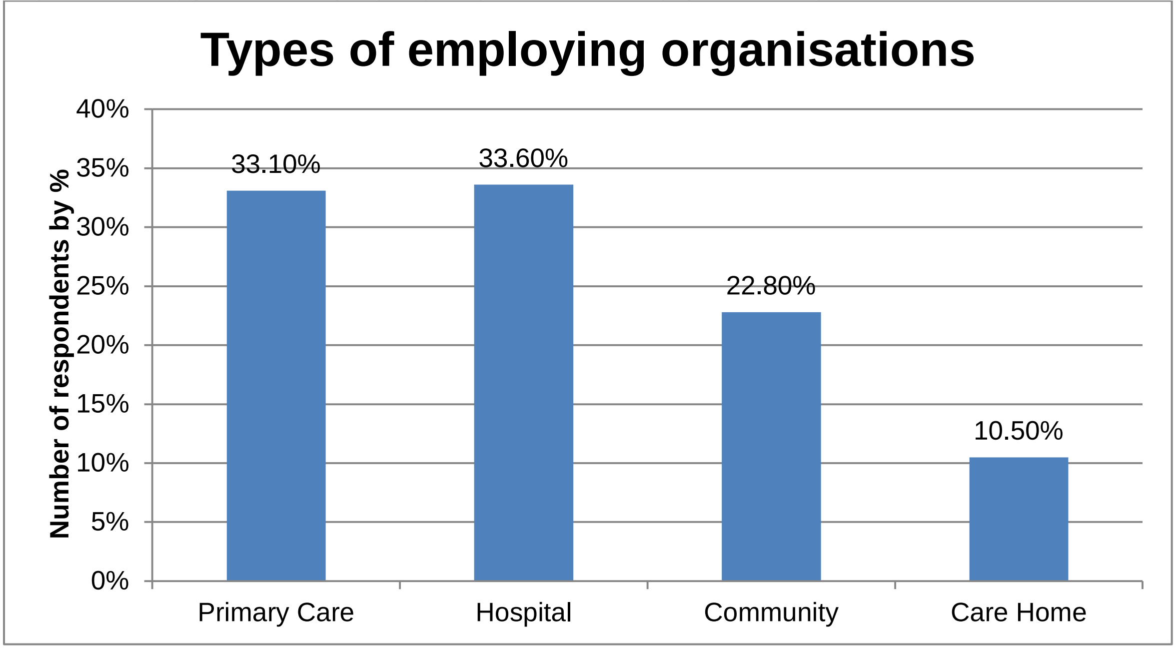
Breakdown of employing organisations

As the Health Education England's priorities are to train staff working in the NHS settings, most participants received the training were employed in the health and social care sector within the NHS. As shown in Table 19 and Figure 36, most participants reported to work in primary care (n = 333, 33.1%) or hospital (n = 338, 33.6%) settings. The remaining participants either worked in the community or in care home settings.

Table 19: Number of participants by employing organisations

Types of Employing Organisations	No.
Primary Care	333
Hospital	338
Community	229
Care Home	106

Figure 36: Types of employing organizations by percentage



Contact with clients

As shown in Table 20 and Figure 37, majority of the participants reported to have face-to-face contact with patients or clients (n = 921, 89.7%). More than half of the participants (n = 663, 66.2%) reported to have regular contact with people with dementia (Figure 38).

Table 20: Breakdown of participants with different contacts with clients

Contact with clients	Yes (n)	No (n)
Face-to-face contact with patients/clients	921	106
Regular contact with people with dementia	663	338

Figure 37: Number of participants with or without face-to-face contact with patients/clients by percentage

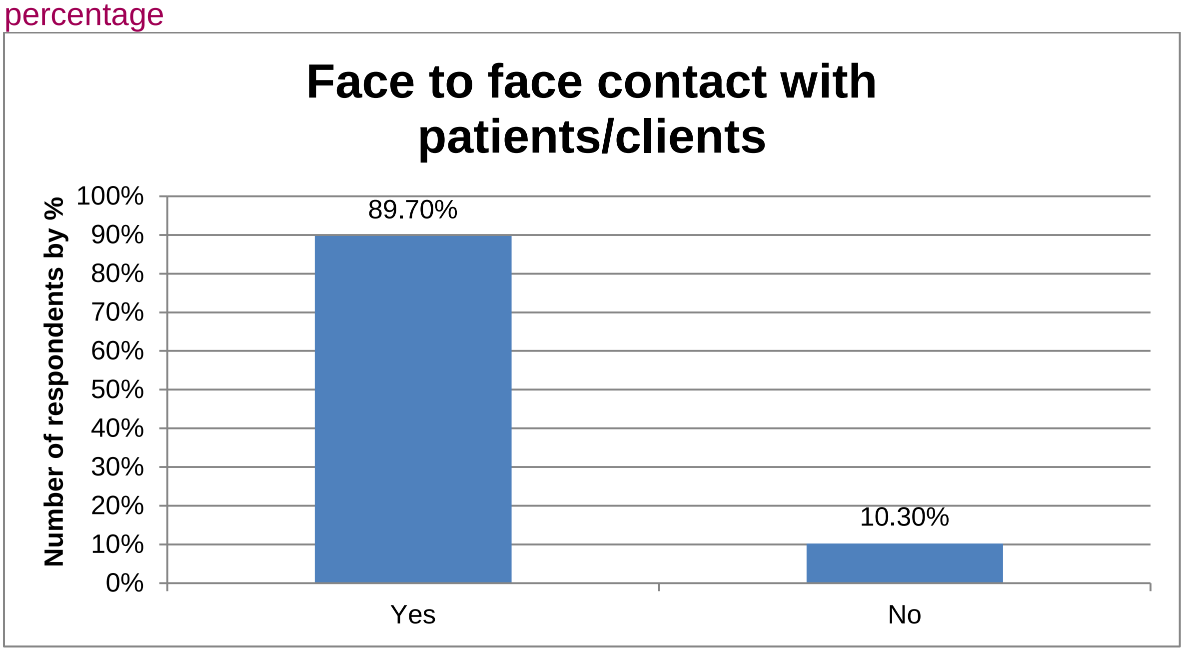
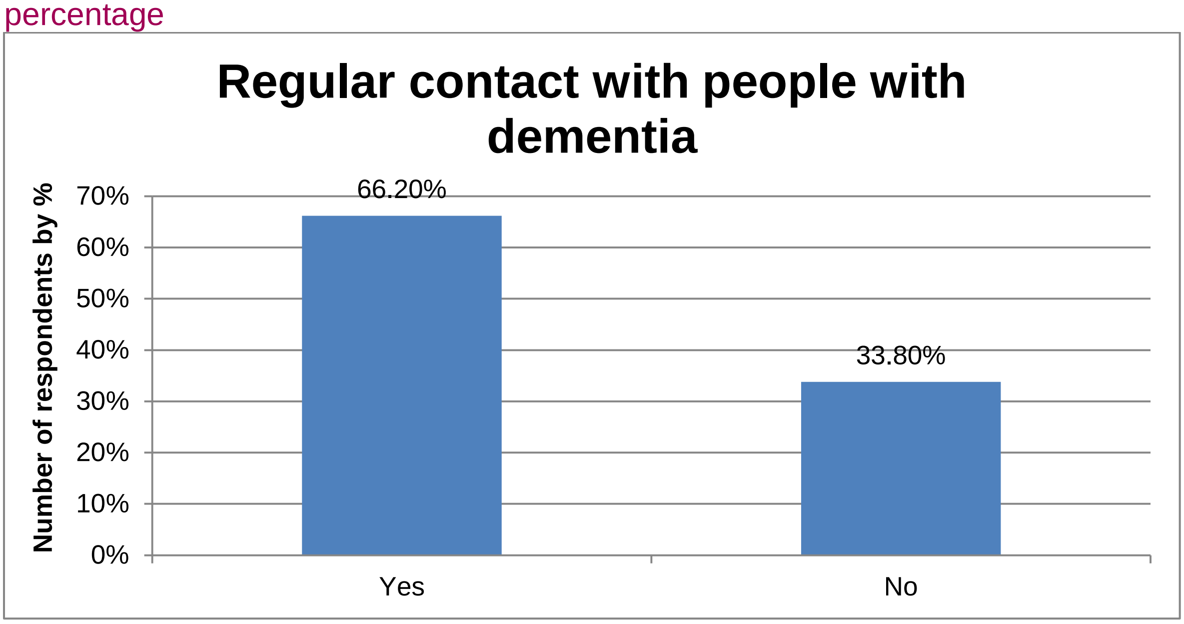


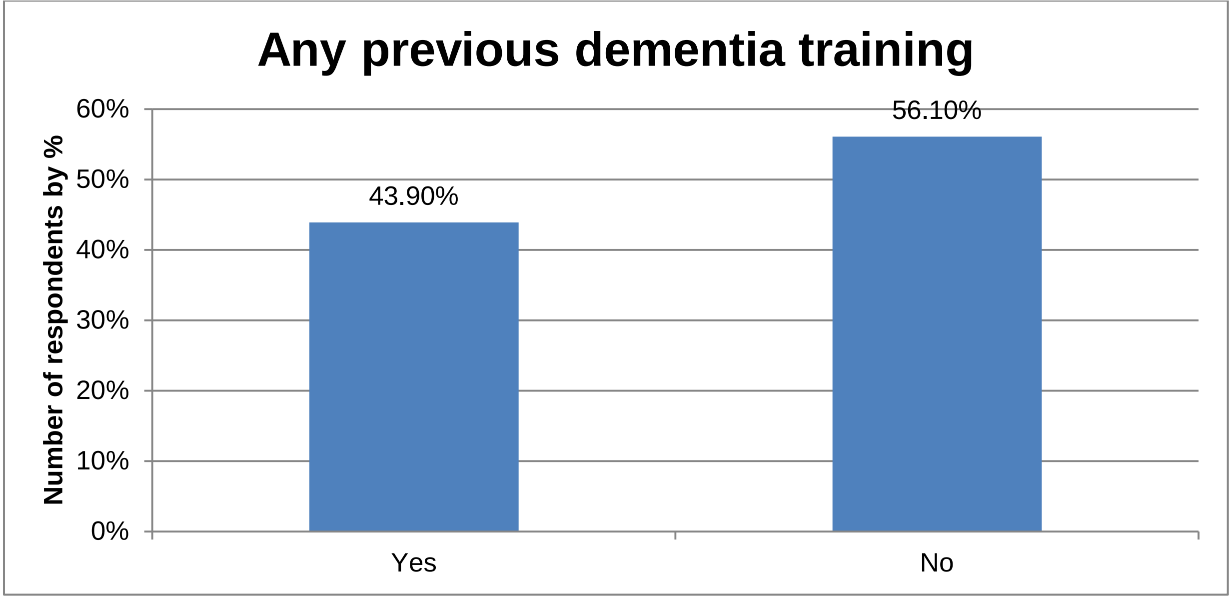
Figure 38: Numbers of participants with or without regular contact with people with dementia by percentage



<u>Previous dementia training</u>

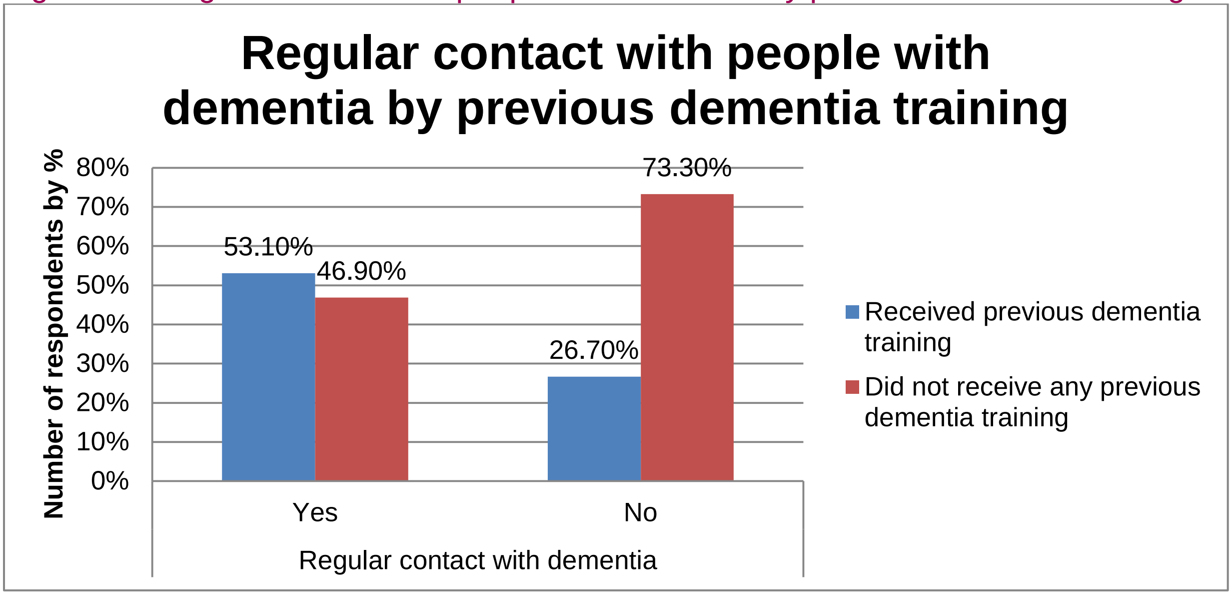
Of the 1033 responses, less than half of the participants reported to have previous dementia training (n = 454, 43.9%) (Figure 39).

Figure 39: Number of participants with or without previous dementia training by percentage



Further crosstab analysis demonstrated that only half of the participants with regular contact with people with dementia (n = 347, 53.1%) had received previous dementia training (Figure 40).

Figure 40: Regular contact with people with dementia by previous dementia training



The group of participants with regular contact with people with dementia and have received previous dementia training are mostly healthcare assistants and registered staff nurse. Over 70 percent of participants with job role categorised under ‘Support to Clinical Staff – Others’ and ‘Others’ indicated that they have regular contact with people with dementia but did not receive any previous dementia training (Table 21).

Among those with regular contact with people with dementia, chi-square of independence results indicated that there is a significant association between whether participants had a clinical or non-clinical role and whether participants had previous dementia training, χ^2 (2, n = 626) = 17.53, p < .001. Participants with a clinical role were more likely to have previous dementia training and participants with a non-clinical role were more likely to not have received any previous dementia training.

Table 21: Participants with regular contact with dementia with or without previous dementia training by employing organisations

	Received any previous dementia training (n = 640)	
Employing organisations	**Yes**	**No**
Medical and Dental	22 (57.9%)	16 (42.1%)
Registered Nurses	70 (54.3%)	59 (45.7%)
Scientific, Therapeutic and Technical	25 (49.0%)	7 (43.8%)
Registered Ambulance Staff	9 (56.3%)	7 (43.8%)
Support to Clinical Staff – Healthcare Assistant (HCA)	138 (69.7%)	60 (30.3%)
Support to Clinical Staff – Others	39(28.5%)	98 (71.5%)
Infrastructure Support	33 (53.2%)	29 (46.8%)
Others	2 (22.2%)	7 (77.8%)

Note. Numbers in parentheses indicate row percentages.

24.1.2 Outcome measures

The following section presents the results collected for the two major outcome measures for the post-training evaluation. The first outcome measure is participants' knowledge about dementia before and after the training and the second outcome measure is participants' changes in attitude, skills and confidence in working with people with dementia as a result of the training. For each outcome measures, data analyses results are organised in sub-sections: 1) analysis by clinical and non-clinical role, 2) analysis by professional categories and 3) analysis by employing organisations.

In the evaluation form, Likert items were utilised to measure the above outcomes. As suggested by Sullivan & Artino (2013), parametric tests were used to perform data analyses and means or frequency distributions of responses were used to describe the data where relevant.

Knowledge about dementia

Participants were presented with six statements describing their knowledge about dementia and were asked to compare their knowledge before and after the dementia training:

- Recognising signs and symptoms of dementia
- Understanding the impact of dementia on individuals, families and society
- Understanding person centred approaches to supporting people with dementia
- Communicating compassionately with people with dementia
- Understanding risk factors for dementia
- Signposting to sources of support

The response rates for each statement are presented in Table 22.

Table 22: Response rate for the six statements describing knowledge about dementia

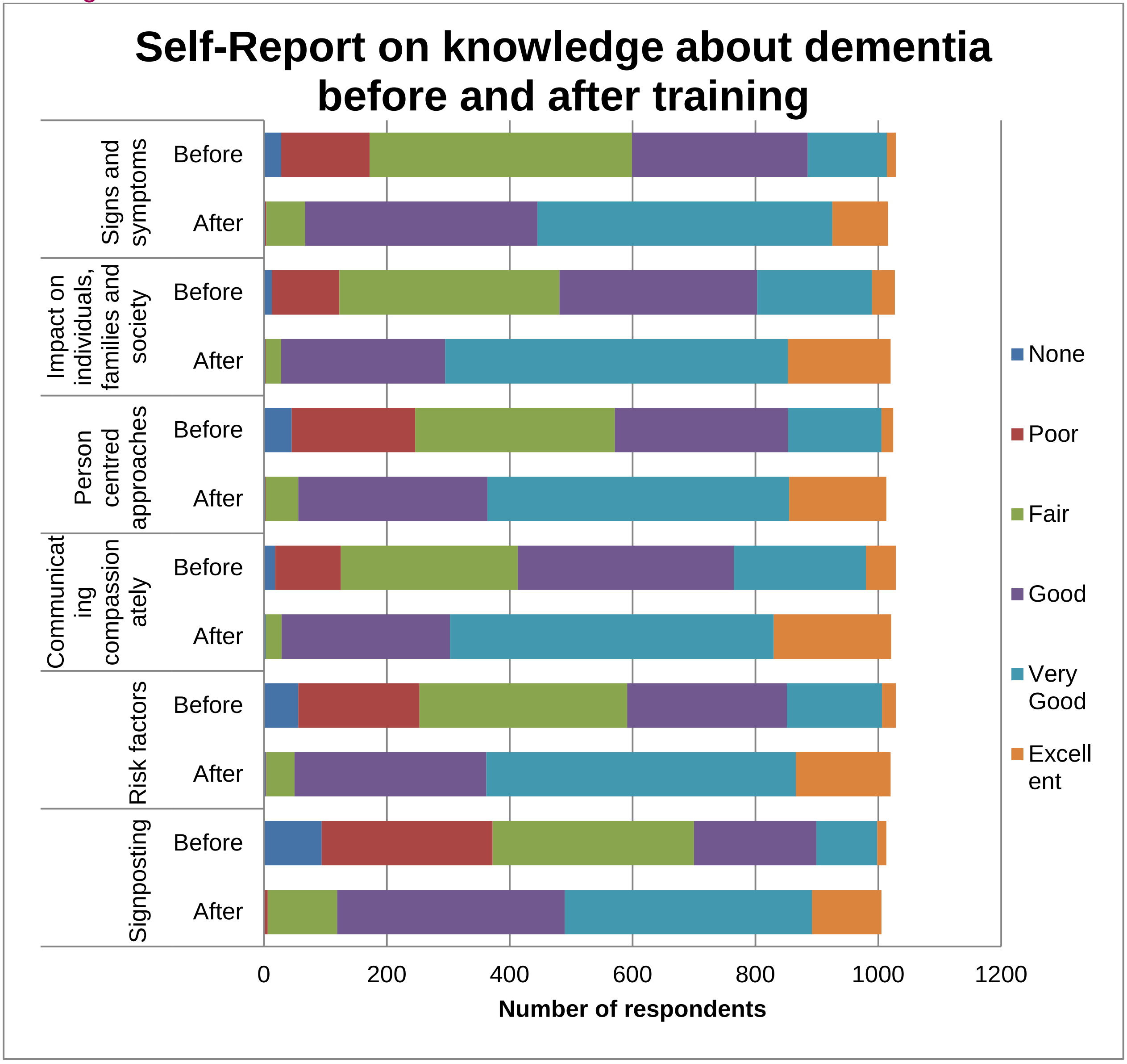
		Total	**Response Rate**
		No.	**%**
Recognising signs and symptoms of dementia	Before	1029	97.4
	After	1016	96.1
Understanding the impact of dementia on individuals, families and society	Before	1027	97.2
	After	1020	96.5
Understanding person centred approaches to supporting people with dementia	Before	1024	96.9
	After	1013	95.8
Communicating compassionately with people with dementia	Before	1029	97.4
	After	1021	96.6
Understanding risk factors for dementia	Before	1029	97.4
	After	1020	96.5
Signposting to sources of support	Before	1013	95.8
	After	1005	95.1

Paired sample t-test was conducted to examine the changes in knowledge about dementia and the results demonstrated that participants' self-reported knowledge on dementia was significantly different before and after training (p <.001). The shift in knowledge level is evident in Table 23 and Figure 41 that there were more participants reported to have good to excellent level of knowledge on the six aspects of dementia after the training. For example, there were only 313 participants (30.9%) reported to have good to excellent level of knowledge in signposting to sources of support before the training. After the training, majority of the participants (n = 886, 88.1%) reported to have at least good level of knowledge on signposting to sources of support.

Table 23: Frequency distribution of responses on knowledge about dementia before and after training

		None		Poor		Fair		Good		Very Good		Excellent	
		No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Recognising signs and symptoms of dementia	Before	28	2.7	144	14	427	41.5	286	27.8	129	12.5	15	1.5
	After	2	0.2	2	0.2	63	6.2	378	37.2	480	47.2	91	9
Understanding the impact of dementia on individuals, families and society	Before	13	1.3	110	10.7	358	34.9	322	31.4	187	18.2	37	3.6
	After	2	0.2	1	0.1	25	2.5	267	26.2	558	54.7	167	16.4
Understanding person centred approaches to supporting people with dementia	Before	45	4.4	201	19.6	325	31.7	282	27.5	152	14.8	19	1.9
	After	2	0.2	1	0.1	53	5.2	308	30.4	491	48.5	158	15.6
Communicating compassionately with people with dementia	Before	18	1.7	107	10.4	288	28	352	34.2	215	20.9	49	4.8
	After	3	0.3	0	0	26	2.5	274	26.8	527	51.6	191	18.7
Understanding risk factors for dementia	Before	56	5.4	197	19.1	338	32.8	260	25.3	155	15.1	23	2.2
	After	3	0.3	1	0.1	46	4.5	312	30.6	504	49.4	154	15.1
Signposting to sources of support	Before	94	9.3	278	27.4	328	32.4	199	19.6	99	9.8	15	1.5
	After	1	0.1	5	0.5	113	11.2	371	36.9	402	40	113	11.2

Figure 41: Frequency distribution of responses on knowledge about dementia before and after training



Differences in knowledge on dementia between clinical and non-clinical staff
Independent t-test results demonstrated that clinical staff reported significantly higher knowledge on all aspects of knowledge about dementia before the training compared to non-clinical staff (p <.001). Following the training, independent t-test results indicated that clinical staff reported significantly higher knowledge about dementia compared to non-clinical staff (p<.001) on the following aspects: recognising signs and symptoms of dementia, understanding person centred approaches to supporting people with dementia, communicating compassionately with people with dementia and understanding risk factors for dementia. There was no significant differences between clinical and non-clinical staff on their knowledge about understanding the impact of dementia on individuals, families and society and signposting to sources of support after the training (Appendix 15).

Differences in knowledge on dementia between professional categories
One-way ANOVA was conducted to further examine whether there was any significant differences between professional categories on self-report knowledge about dementia before and after the training. The results demonstrated that there were significant differences on the

six aspects of knowledge about dementia between professional categories before and after training (p<.005) (see Appendix 16). Before the training, medical and dental staff reported highest knowledge level about recognising signs and symptoms of dementia and understanding risk factors, qualified ambulance staff had the highest knowledge level about communicating compassionately with people with dementia and healthcare assistants scored the highest knowledge level on understanding the impacts of dementia, understanding person centred approaches and signposting to sources of support. Following the training, participants with job role categorised under 'Support to Clinical Staff – HCA' reported higher knowledge level on all aspects of dementia compared to participants with other job role, except on understanding risk factors for dementia in which qualified ambulance staff reported to have the highest knowledge level.

As the healthcare assistants and other clinical support staff (e.g., administrators, receptionists) were separated into two groups within the 'Support to Clinical Staff' professional category, independent t-tests were performed to examine whether there was any significant differences in self-report knowledge level about dementia between healthcare assistants and other clinical support staff before and after the training. Before the training, the independent t-test results demonstrated that healthcare assistants only reported significantly higher knowledge level about communicating compassionately with people with dementia compared to other clinical support staff (p = .001). There were no significant differences on the other aspects of knowledge about dementia between the two groups before the training. Following the training, participants with job role categorised under 'Support to Clinical Staff – HCA' scored significantly higher across six aspects of knowledge level about dementia than participants with job role categorised under 'Clinical Support to Staff – Others' (Appendix 17).

Differences in knowledge on dementia between employing organisations

One-way ANOVA results revealed that there were significant differences on the six aspects of dementia knowledge level before and after training between employing organisations (p<.001) (Appendix 18). Participants working in care home settings reported significantly higher knowledge level on the six aspect of dementia knowledge before and after the training compared to other participants working in primary care, hospital and community settings.

Improved attitudes, skills and confidence

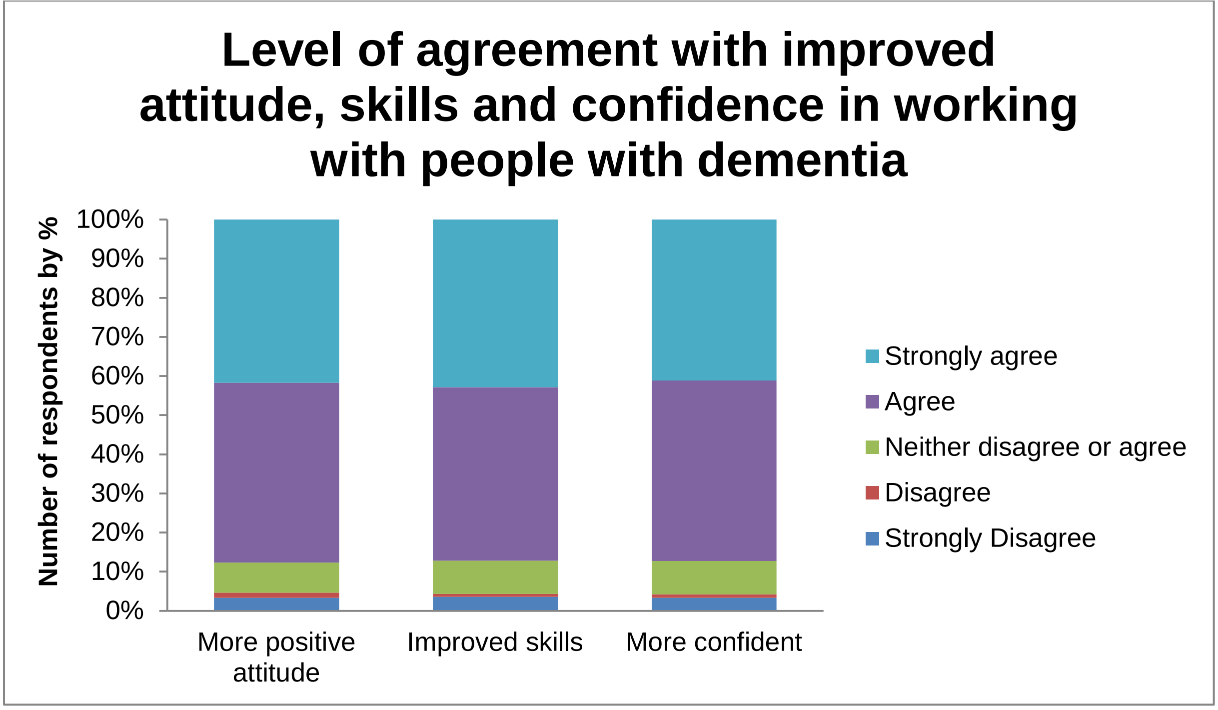
In addition to participants' knowledge gained, the evaluation forms also presented participants with three statements describing their changes in attitude, skills and confidence in working with people with dementia. The response rate for the three statements is displayed in Table 24.

Table 24: Response rate for the three statements on improved attitude, skills and confidence in working with people with dementia

Statements	Number of responses received (No.)	Response Rate (%)
I feel my attitude to people with dementia is more positive.	1024	96.9%
I feel this training has improved my skills in working with people with dementia.	1018	96.3%
I feel more confident in interacting with people with dementia.	1023	96.8%

As shown in Figure 42, more than 80% of the participants agreed or strongly agreed that their attitude to people with dementia was more positive (n = 898, 87.7%), their skills in working with people with dementia had improved (n = 888, 87.2%) and their confidence in interacting with people with dementia had increased (n = 893, 87.3%) as a result of the training. Most of the participants disagreed with the three statements had job role categorised under 'Support to Clinical Staff – Others'.

Figure 42: Participants' level of agreement with improved attitude, skills and confidence in working with people with dementia as a result of the training



<u>Differences in improved attitude, skills and confidence between clinical and non-clinical staff</u>
Chi-square tests for independence results indicated that there was no significant association between improved attitude, skills and confidence in working with people with dementia and whether the participants had a clinical or non-clinical role (Table 25, 26 and 27). The results suggested that participants with a clinical or non-clinical role had similar level of agreement to whether their attitude, skills and confidence in working with people with dementia had changed as a result of the training. More than 80% of the participants with a clinical or non-clinical role agreed that their attitude, skills and confidence in working with people with dementia has improved as a result of the dementia training. Less than 5 percent of the participants with a clinical or non-clinical role disagreed and about 7 to 10 percent of the participants with a clinical or non-clinical role neither agreed nor disagreed that their attitude, skills and confidence had changed as a result of the dementia training.

Table 25: Results of Chi-square test and descriptive statistics for clinical and non-clinical role by level of agreement of more positive attitude in working with people with dementia

	More positive attitude		
Role (n = 993)	**Agree**	**Neither agree or disagree**	**Disagree**
Clinical	465 (87.2%)	42 (7.9%)	26 (4.9%)
Non-clinical	405 (88.0%)	35 (7.6%)	20 (4.3%)

Note. χ^2 =.105, df = 2, p = .909. Numbers in parentheses indicate row percentages.

Table 26: Results of Chi-square test and descriptive statistics for clinical and non-clinical role by level of agreement of improved skills in working with people with dementia

	Improved skills		
Role (n = 987)	**Agree**	**Neither agree or disagree**	**Disagree**
Clinical	471 (88.5%)	37 (7.0%)	24 (4.5%)
Non-clinical	387 (85.1%)	49 (10.8%)	19 (4.2%)

Note. χ^2 = 4.5, df = 2, p = .105. Numbers in parentheses indicate row percentages.

Table 27: Results of Chi-square test and descriptive statistics for clinical and non-clinical role by level of agreement of more confident in working with people with dementia

	More confident		
Role (n = 992)	**Agree**	**Neither agree or disagree**	**Disagree**
Clinical	464 (87.2%)	45 (8.5%)	23 (4.3%)
Non-clinical	399 (86.7%)	42 (9.1%)	19 (4.1%)

Note. χ^2 =.155, df = 2, p = .925. Numbers in parentheses indicate row percentages.

<u>Differences in improved attitude, skills and confidence between professional categories</u>
Chi-square test for independence was unable to perform as there were more than 20 percent of the cells with expected count less than 5 and the assumption for the chi-square test was violated. However, it is shown in Table 28, 29 and 30 that majority of the participants across all professional categories agreed that their attitude, skills and confident in working with people with dementia has improved as a result of the training. Among those participants who disagreed that their attitude, skills and confident have changed, most participants had job role providing infrastructure or clinical support to staff.

Table 28: Descriptive statistics for level of agreement with more positive attitude in working with people with dementia by professional categories

	More positive attitude		
Professional Categories (n = 992)	Agree	Neither agree or disagree	Disagree
Medical and Dental	37 (88.1%)	4 (9.5%)	1 (2.4%)
Registered Nurses	164 (89.6%)	12 (6.6%)	7 (3.8%)
Scientific, Therapeutic and Technical Staff	71 (85.5%)	10 (12.0%)	2 (2.4%)
Qualified Ambulance Staff	14 (87.5%)	2 (12.5%)	0
Support to Clinical Staff – HCA	200 (88.5%)	14 (6.2%)	12 (5.3%)
Support to Clinical Staff - Others	228 (86.0%)	23 (8.7%)	14 (5.3%)
Infrastructure Support Staff	121 (88.3%)	8 (5.8%)	8 (5.8%)
Others	35 (87.5%)	4 (10.0%)	1 (2.5%)

Note. Numbers in parentheses indicate row percentages.

Table 29: Descriptive statistics for level of agreement with improved skills in working with people with dementia by professional categories

	Improved skills		
Professional Categories (n = 986)	Agree	Neither agree or disagree	Disagree
Medical and Dental	37 (88.1%)	4 (9.5%)	1 (2.4%)
Registered Nurses	169 (92.3%)	6 (3.3%)	8 (4.4%)
Scientific, Therapeutic and Technical Staff	76 (91.6%)	5 (6.0%)	2 (2.4%)
Qualified Ambulance Staff	13 (81.3%)	3 (18.8%)	0
Support to Clinical Staff – HCA	202 (89.4%)	13 (5.8%)	11(4.9%)
Support to Clinical Staff - Others	219 (83.6%)	31(11.8%)	12 (4.6%)
Infrastructure Support Staff	111 (82.8%)	14 (10.4%)	9 (6.7%)
Others	34 (85.0%)	5 (12.5%)	1 (2.5%)

Note. Numbers in parentheses indicate row percentages

Table 30: Descriptive statistics for level of agreement with more confident in working with people with dementia by professional categories

	More confident		
Professional Categories (n = 991)	Agree	Neither agree or disagree	Disagree
Medical and Dental	33 (78.6%)	8 (19.0%)	1 (2.4%)
Registered Nurse	168 (91.8%)	7 (3.8%)	8 (4.4%)
Scientific, Therapeutic and Technical Staff	74 (89.2%)	7 (8.4%)	2 (2.4%)
Qualified Ambulance Staff	13 (81.3%)	3 (18.8%)	0
Support to Clinical Staff – HCA	203 (89.8%)	12 (5.3%)	11 (4.9%)
Support to Clinical Staff - Others	227 (86.0%)	25 (9.5%)	12 (4.5%)
Infrastructure Support Staff	117 (85.4%)	12 (8.8%)	8 (5.8%)
Others	31 (77.5%)	8 (20.0%)	1 (2.5%)

Note. Numbers in parentheses indicate row percentages

Differences in improved attitude, skills and confidence between employing organisations

Chi-square tests for independence results indicated that there was no significant association between improved attitude, skills and confidence in working with people with dementia and participants' employing organisations (Table 31, 32 and 33). Majority of the participants working in primary care, hospital, community and care home settings agreed that their attitude, skills and confident in working with people with dementia has improved as a results of the training. Across all four employing organisations, less than 20 percent of the participants had no opinion or disagree that their attitude, skills and confidence has changed as a result of the training.

Table 31: Results of Chi-square test and descriptive statistics for employing organisations by level of agreement of more positive attitude in working with people with dementia

	More positive attitude		
Employing organisations (n = 981)	**Agree**	**Neither agree or disagree**	**Disagree**
Primary care	293 (89.1%)	27 (8.2%)	9 (2.7%)
Hospital	278 (87.1%)	21 (6.6%)	20 (6.3%)
Community	194 (85.5%)	20 (8.8%)	13 (5.7%)
Care home	97 (91.5%)	5 (4.7%)	4 (3.8%)

Note. χ^2 = 7.67, df = 6, p = .263. Numbers in parentheses indicate row percentages.

Table 32: Results of Chi-square test and descriptive statistics for employing organisations by level of agreement of improved skills in working with people with dementia

	Improved skills		
Employing organisations (n = 975)	**Agree**	**Neither agree or disagree**	**Disagree**
Primary care	295 (90.2%)	23 (7.0%)	9 (2.8%)
Hospital	272 (86.1%)	27 (8.5%)	17(5.4%)
Community	189 (83.6%)	25 (11.1%)	12(5.3%)
Care home	96 (90.6%)	5 (4.7%)	5(4.7%)

Note. χ^2 = 8.41, df = 6, p = .210. Numbers in parentheses indicate row percentages.

Table 33: Results of Chi-square test and descriptive statistics for employing organisations by level of agreement of more confident in working with people with dementia

	More confident		
Employing organisations (n = 980)	**Agree**	**Neither agree or disagree**	**Disagree**
Primary care	294 (89.4%)	26 (7.9%)	9 (2.7%)
Hospital	274 (86.2%)	27 (8.5%)	17 (5.3%)
Community	192 (84.6%)	24 (10.6%)	11 (4.8%)
Care home	96 (90.6%)	5 (4.7%)	5 (4.7%)

Note. χ^2 = 6.52, df = 6, p = .368. Numbers in parentheses indicate row percentages.

24.2 Six weeks follow-up (paper questionnaires)

24.2.1 Descriptive

Of the 1057 participants involved in the immediate evaluation, 131 participants (12.39%) self-selected and completed the six weeks follow-up questionnaires. These participants either completed the questionnaire online or returned the paper questionnaires.

Professional titles and role

Similar to the immediate evaluation results, participants' job titles were classified using the HEE guidance on reporting professional titles (Figure 43). Thirty participants (22.9%) were categorized under the 'Support to Clinical Staff – HCA' job category; 29 participants (22.1%) were categorized under the 'Support to Clinical Staff – Other' and 29 participants (22.1%) were categorized under the 'Infrastructure support' job category. Twenty-six participants (19.8%) were categorized under the 'Registered Nurse' category. The rest of the participants were categorized either under the 'Scientific, Therapeutic and Technical' (n = 9, 6.9%) or 'Medical and Dental' (n = 6, 4.6%) category. None of the registered ambulance staff participated in the six weeks follow-up. More than half of the participants (n = 70, 53.4%) reported to have a non-clinical role (Figure 44).

Figure 43: Breakdown of professional categories by percentage

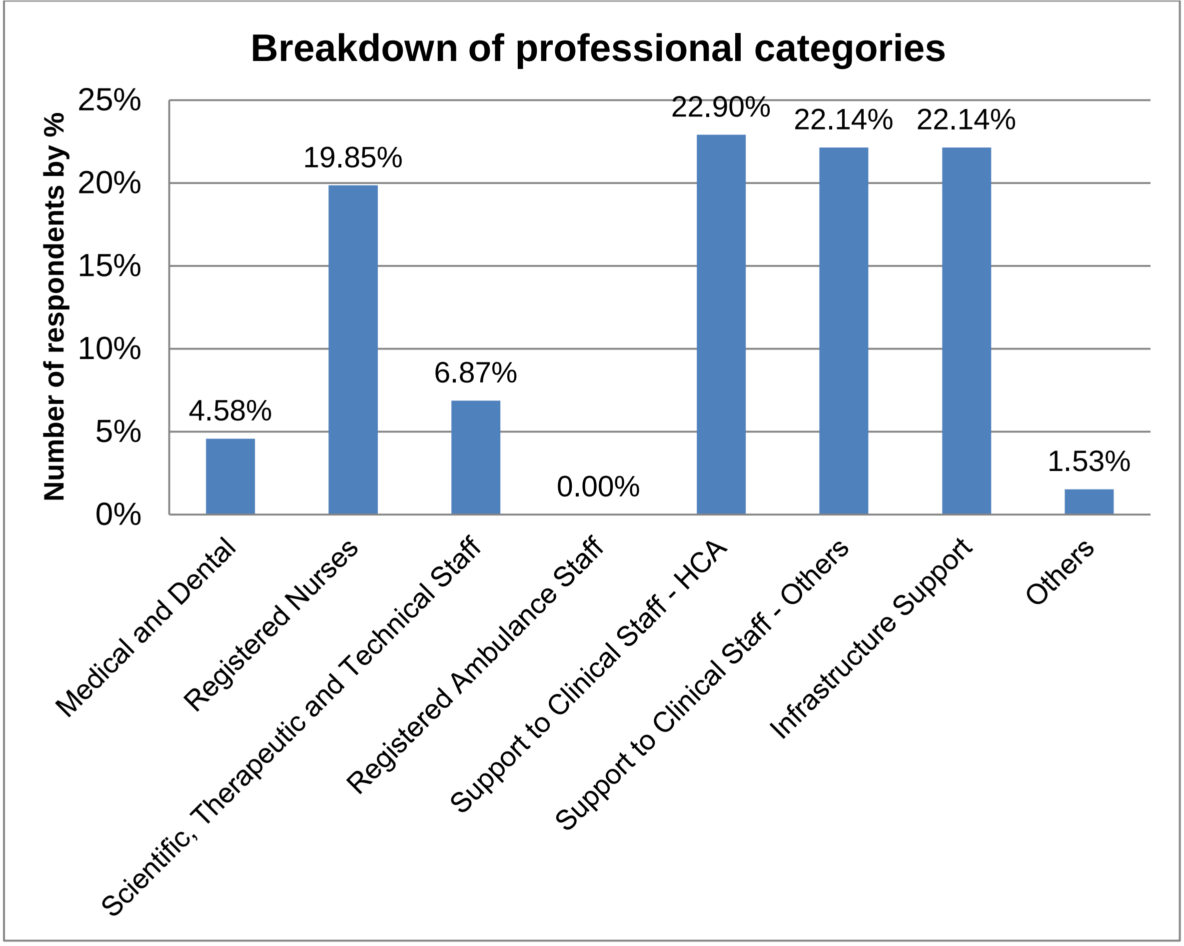
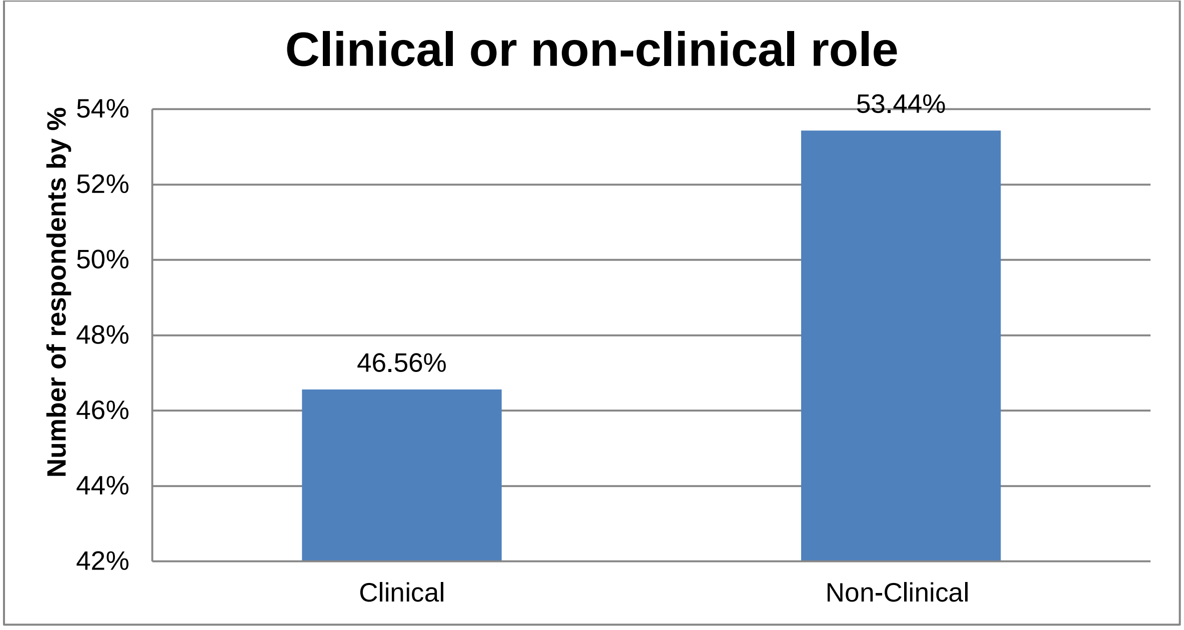


Figure 44: Breakdown of participants with clinical or non-clinical role by percentage



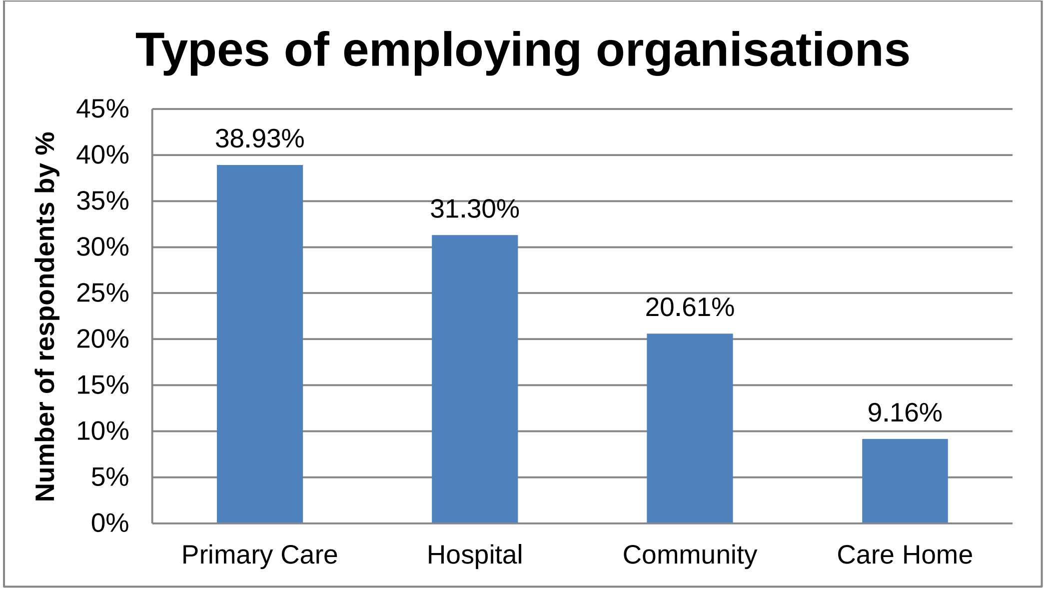
Breakdown of employing organisations

As indicated in Table 34 and Figure 45, most participants reported to work in a primary (n = 51, 38.9%) or hospital (n = 41, 31.3%) settings. The remaining of the participants worked in the communities or care homes.

Table 34: Types of employing organisations

Types of Employing Organisations	No.
Primary Care	51
Hospital	41
Community	27
Care Home	12

Figure 45: Types of employing organisations by percentage



Contact with clients

Similar to the results obtained in the immediate evaluation, majority of the participants reported to have face-to-face contact with patients (n = 110, 84.0%) (Figure 46). Just about half of the participants reported to have regular contact with people with dementia in their job role (n = 79, 60.3%) (Figure 47).

Figure 46: Participants with or without face-to-face contact with patients/clients by percentage

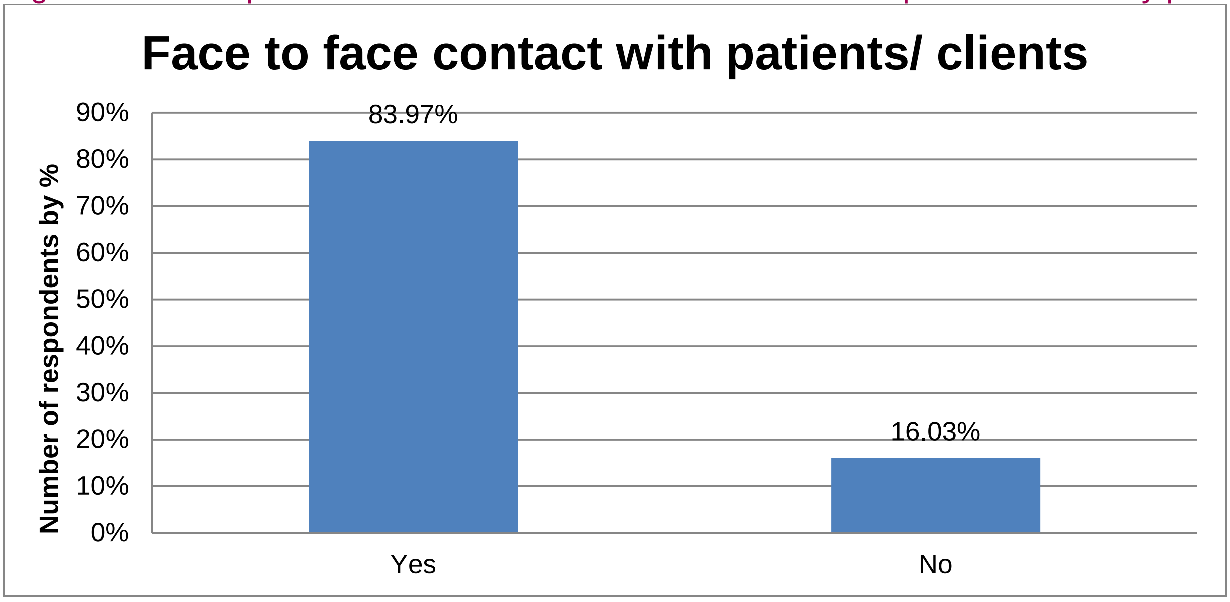
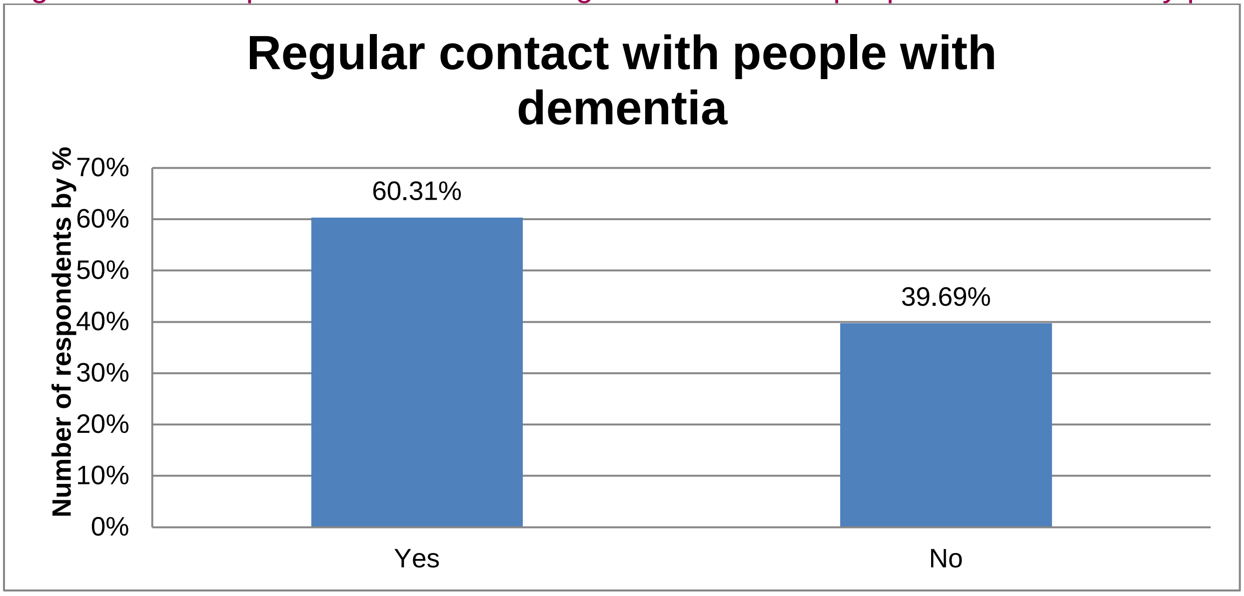


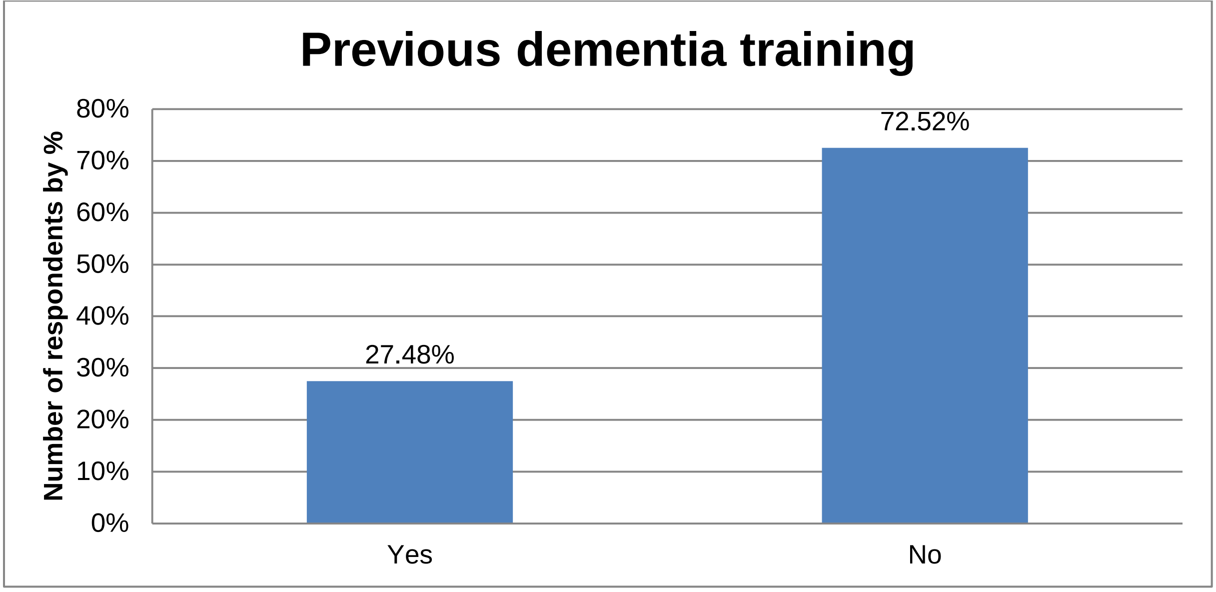
Figure 47: Participants with or without regular contact with people with dementia by percentage



Previous dementia training

In contrast to the immediate evaluation results, more than half of the participants (n = 95, 72.5%) have not untaken any other dementia training (Figure 48). Over half of the participants (n = 50, 63.3%) reported to have regular contact with people with dementia but did not received any prior dementia training.

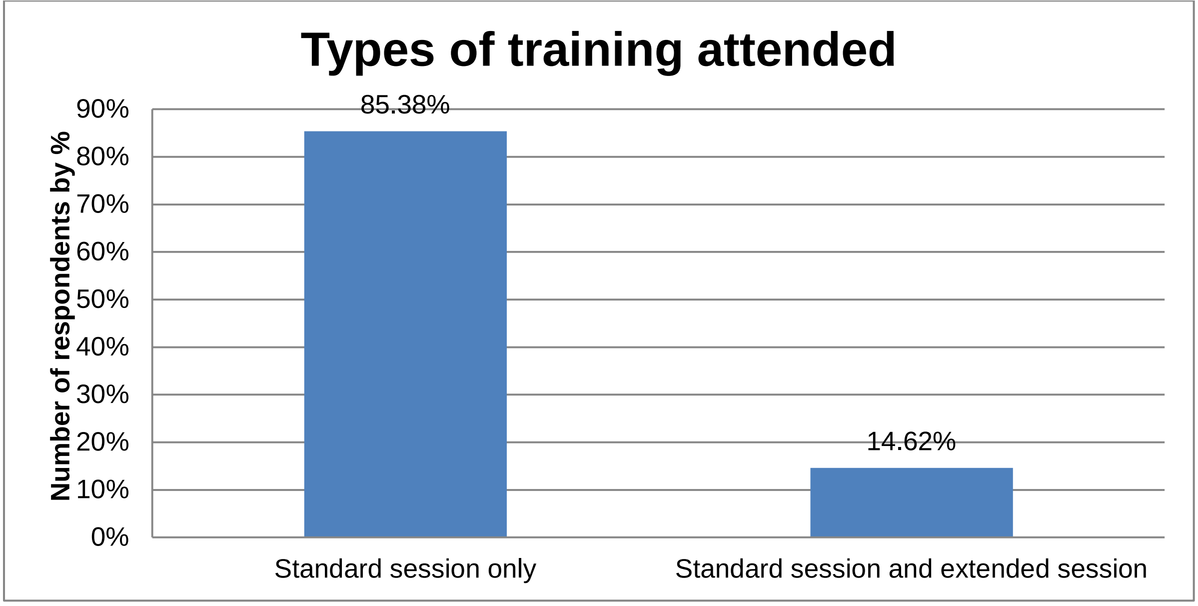
Figure 48: Participants with or without previous dementia training by percentage



Training attended

Of the 130 responses received, majority of the participants (n = 111, 85.4%) attended the standard session only, which covered information on understanding, recognising and interacting with people with dementia (Figure 49). Nineteen participants (14.6%) attended both the standard and extended session. Of which, 17 participants attended the two sessions on the same day and 2 participants attended the two sessions within 1 month of each other. The extended session covered additional information, including the 3D's, Vera framework, decision making and the Mental Capacity Act.

Figure 49: Types of training attended by percentage

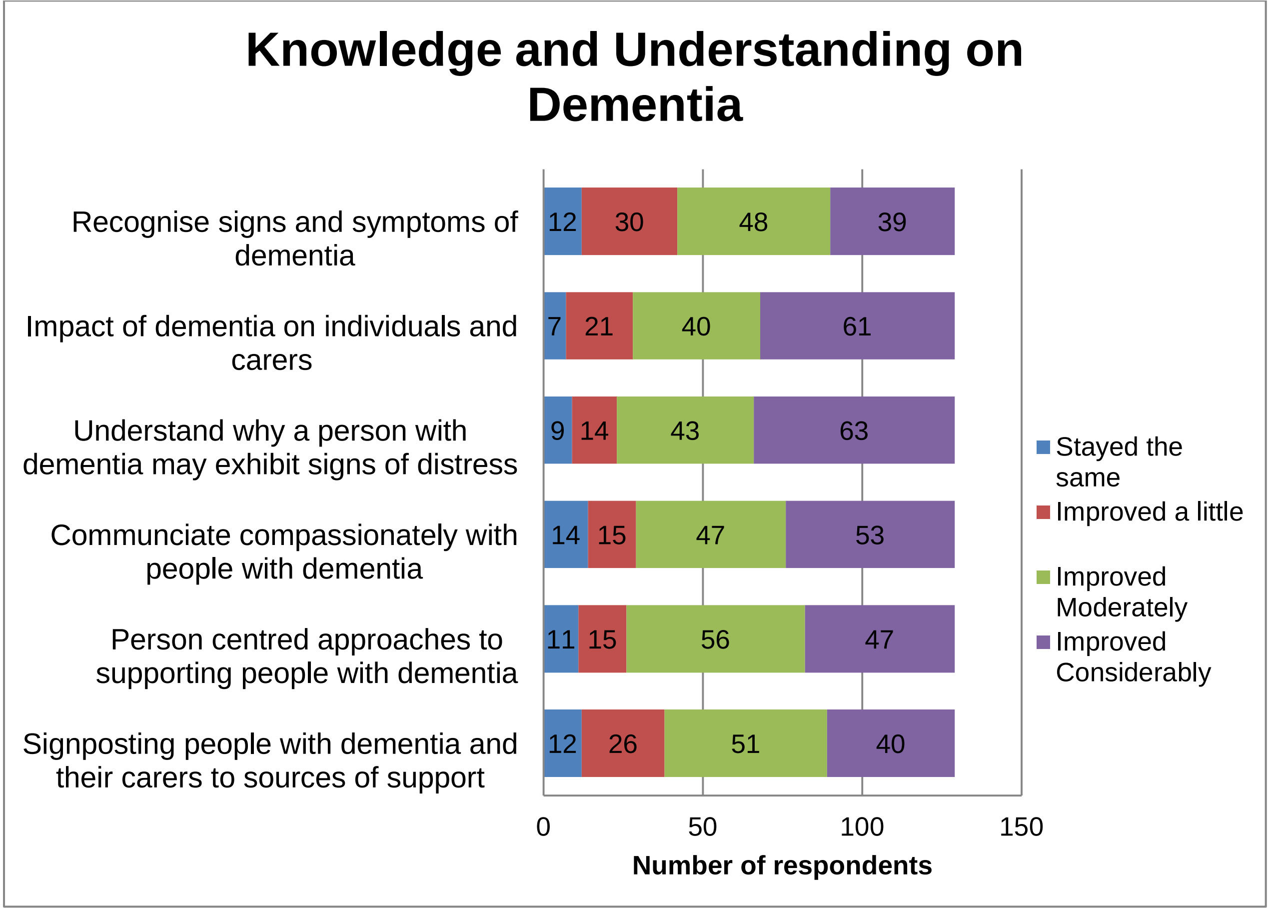


24.2.2 Outcome measures

Knowledge and understanding about dementia

Of the 131 responses, at least ninety percent of the participants reported that their knowledge and understanding on dementia had improved as a result of the training (Figure 50). Only a small percentage of participants (5.4%-10.9%), mostly healthcare assistants, registered nurses and infrastructure support staff reported no change in knowledge and understanding on dementia.

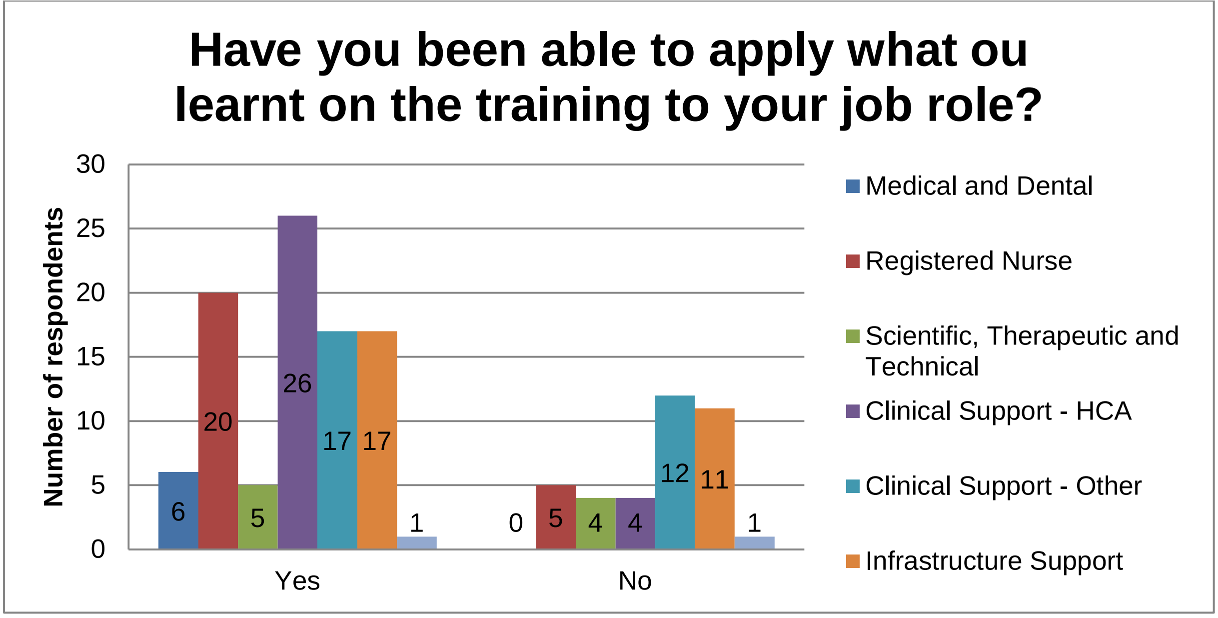
Figure 50: Levels of agreement to statements describing participants' knowledge and understanding on dementia



Transferring training to practice

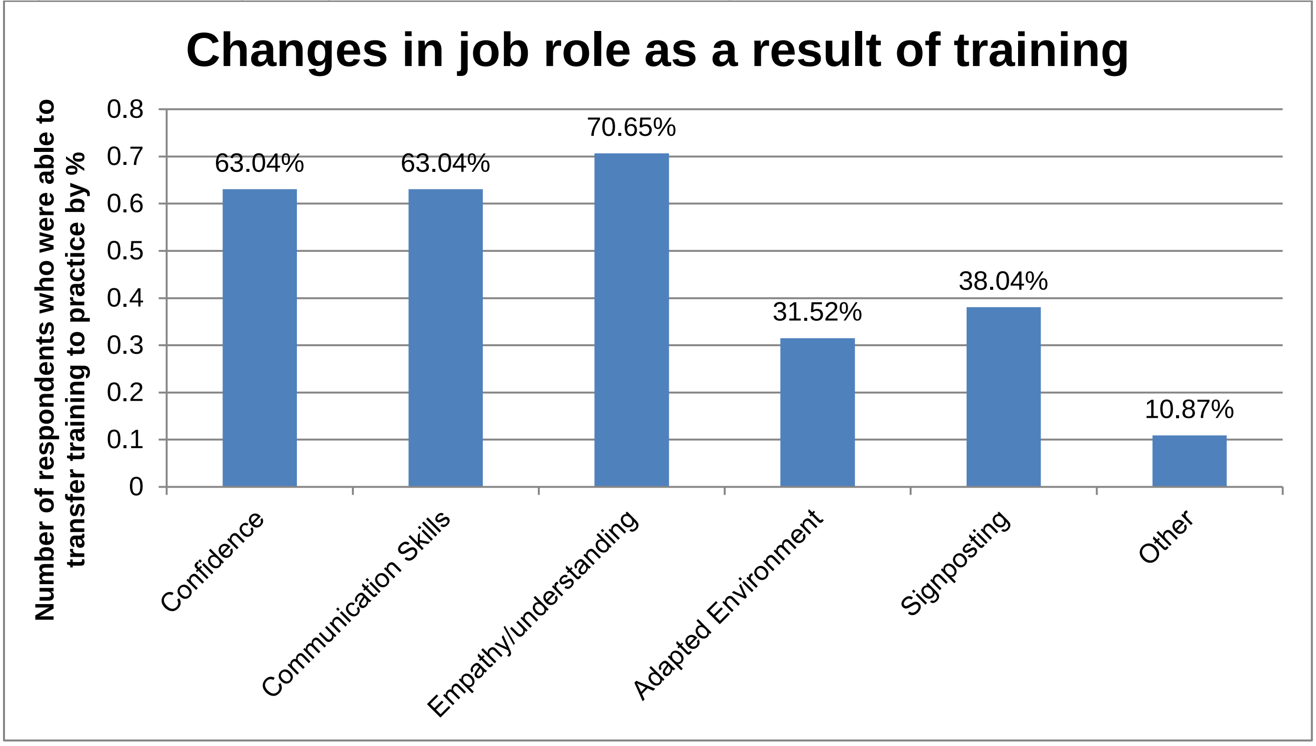
Of the 131 responses, 70.2% (n = 92) of participants reported that they had been able to apply training to their job role. As demonstrated in Figure 51, this group of participants consists mostly of healthcare assistants (n= 26, 28.3%) and registered nurse (n = 20, 21.7%). Of the 39 participants (29.8%) who had not been able to apply knowledge to job role, most participants had job role categorised under 'Support to Clinical Staff – Others' (n = 12, 32.4%) and 'Infrastructure Support' (n = 11, 29.7%).

Figure 51: Apply training to job role by professional categories



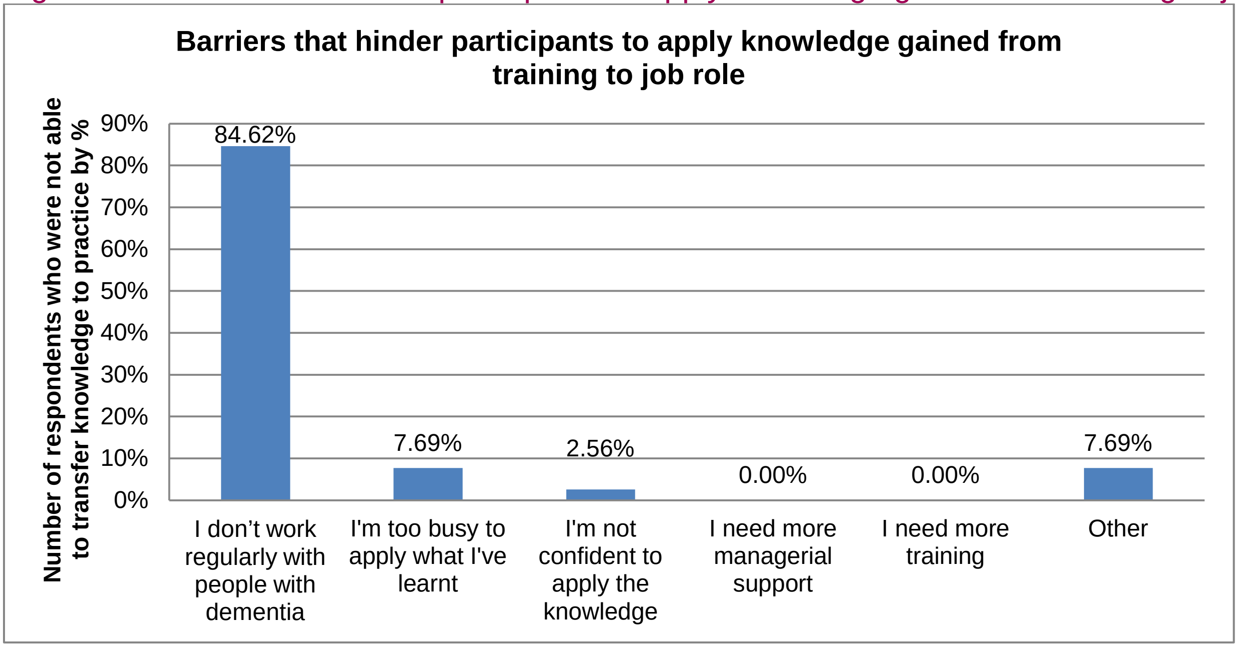
For those participants who have been able to transfer knowledge to practice (n = 92), they were asked to identify areas in their job role that have changed as a result of the training. The results are displayed in Figure 52 and all areas are not mutually exclusive. As shown in Figure 52, more than half of the participants (n = 65, 70.7%) have identified ‘empathy and understanding’ as an area that has changed due to the dementia training. This is followed by ‘confidence’ and ‘communication skills’, both with 58 participants (63.0%) identified as areas that have changed as a result of the training. Thirty five participants (38.0%) and 29 participants (31.5%) have also selected ‘signposting’ and ‘adapted environment’ as two areas that have changed as a result of the training respectively. Ten participants (10.9%) indicated other areas that were not listed as an option have changed as a result of the training.

Figure 52: Changes in job role as a result of training



Among those participants who have not been able to apply knowledge gained from training to their job role (n = 39), they were asked to identify any barriers that they think may hinder them in transferring training to practice. As shown in Figure 53, majority of the participants (n = 33, 84.6%) indicated that their lack of contact with people with dementia was the reason why they have not been able to apply their knowledge. Three participants (7.69%) indicated that they were too busy to apply what they have learned and only one participant (2.56%) mentioned that he or she was not confident to apply the knowledge. No participants have indicated that they need more managerial support or more training. Three participants (7.69%) have indicated that there were other barriers that were not listed as an option.

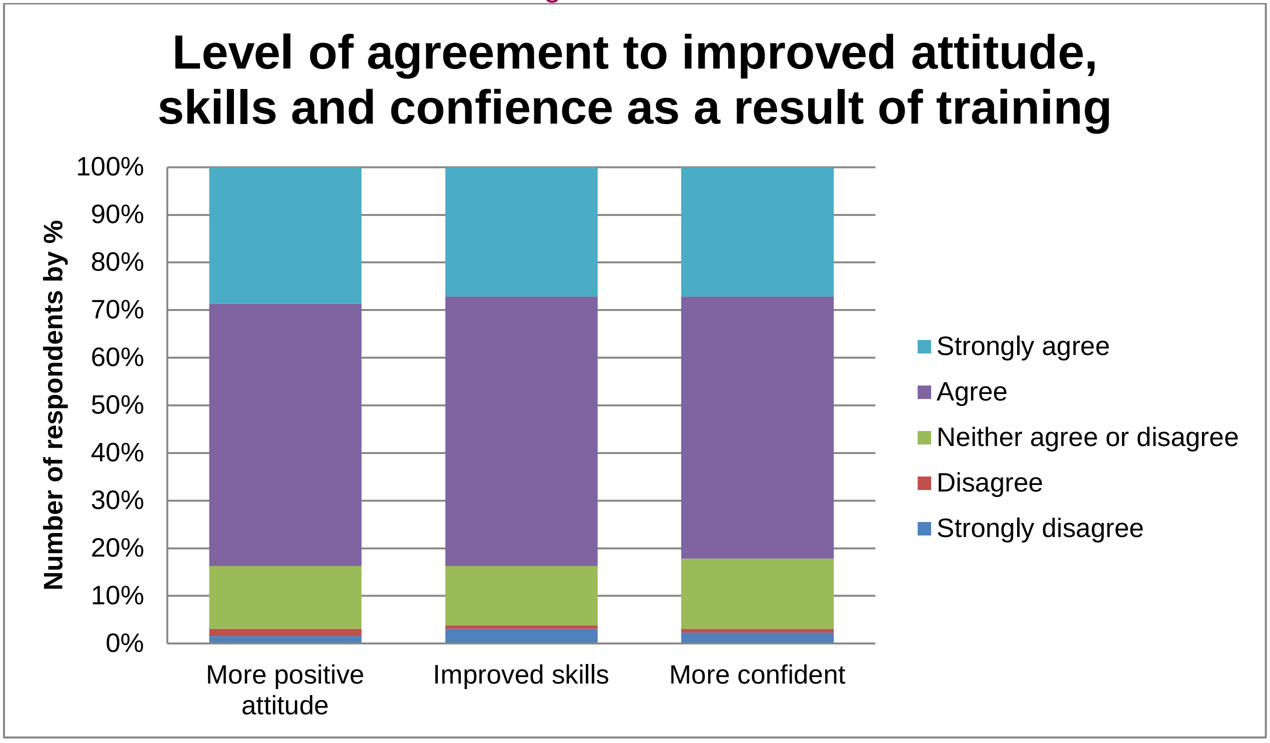
Figure 53: Barriers that hinder participants to apply knowledge gained from training to job role



Attitude, skills and confidence

Similar to the immediate training evaluation, participants were asked to rate their level of agreement with the three statements describing their changes in attitude, skills and confidence in working with people with dementia. Majority of the participants either agreed or strongly agreed that their attitude towards people with dementia is more positive (n = 108, 83.7%), the training has improved their skills in working with people with dementia (n = 108, 83.7%) and they feel more confident in interacting with people with dementia (n = 106, 82.2%) (Figure 54). Of those who disagreed their attitude, skills and confident have improved as a result of the training, some participants have indicated in the previous question that they have not been able to apply training to practice. Further crosstab results indicated that there was not a specific professional categories associated with the participants who reported no changes in their attitude, skills and confident.

Figure 54: Level of agreement to improved attitude, skills and confident in working with people with dementia as a result of the training

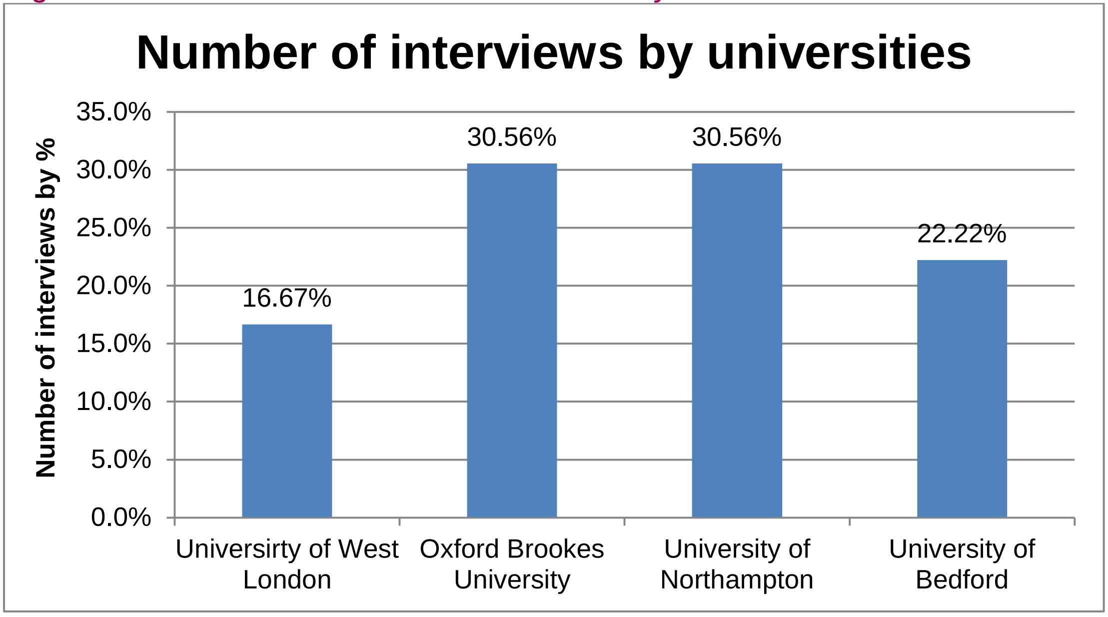


24.3 Six weeks follow-up (semi-structured interviews)

24.3.1 Descriptive

Out of the 1057 participants in the immediate evaluation, 36 participants (3.41%) agreed to be contacted for a ten minutes telephone semi-structured interview in six weeks following the training. A breakdown of the number of telephone interviews undertaken by each university is displayed in Figure 55. Oxford Brookes University and University of Northampton each conducted 11 interviews; University of Bedford conducted 8 interviews and University of West London conducted 6 interviews.

Figure 55: Number of interviews undertaken by universities



Breakdown of professional categories and roles

Participants' job role were categorised using the HEE guidance on reporting professional titles (Figure 56). Among the participants who have participated in the telephone interviews, most of the participants had job role in the following four categories: 'Support to Clinical Staff – HCA' (n = 8, 22.2%), 'Infrastructure support' (n = 8, 22.2%), 'Registered nurse' (n = 7, 19.4%) and 'Support to Clinical Staff – Others' (n = 7, 19.4%). The remaining participants had job role categorised under 'Scientific, Therapeutic and Technical' (n = 3, 8.3%) or 'Medical and Dental' (n = 2, 5.6%). No participants from the 'Registered Ambulance Staff' group participated in the six weeks telephone follow-up. Of the 28 responses received, 17 participants (60.7%) reported to have a clinical role and 11 participants (30.6%) reported to have a non-clinical role (Figure 57). The response rate for questions on participants' jobs and contact with clients was low as some of these questions were not asked in the interview and/or participants chose not to answer.

Figure 56: Breakdown of professional categories by percentage

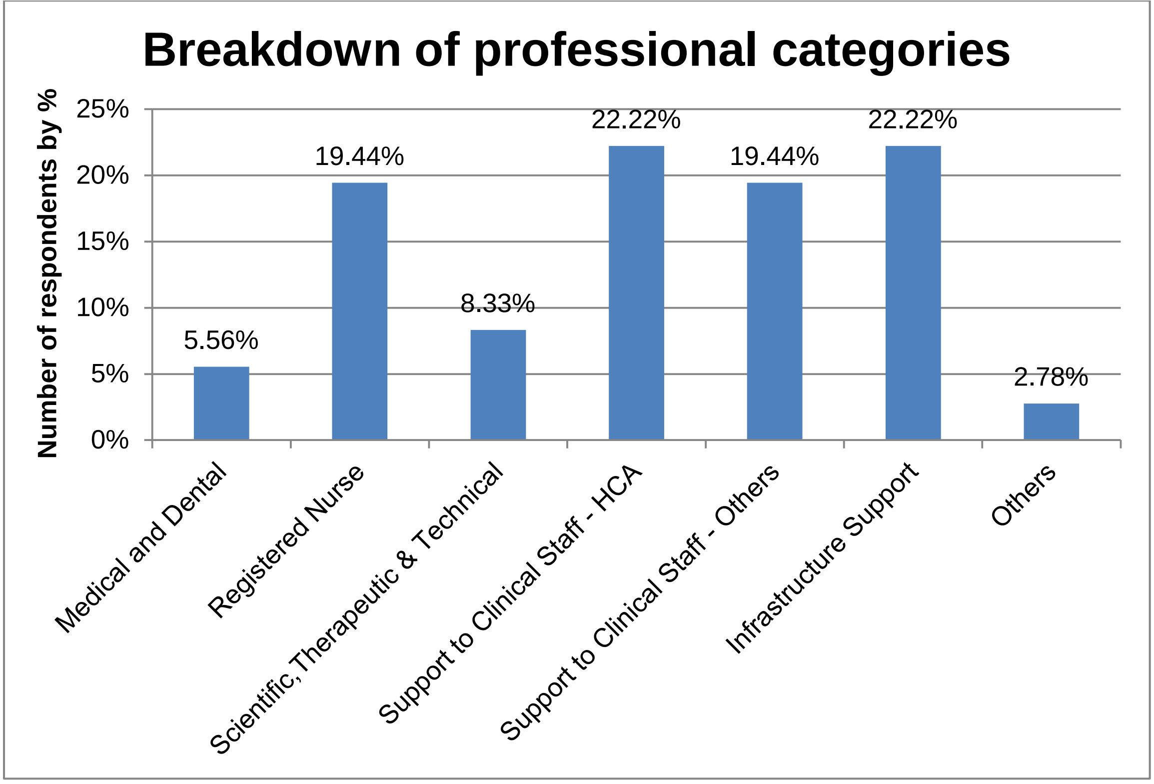
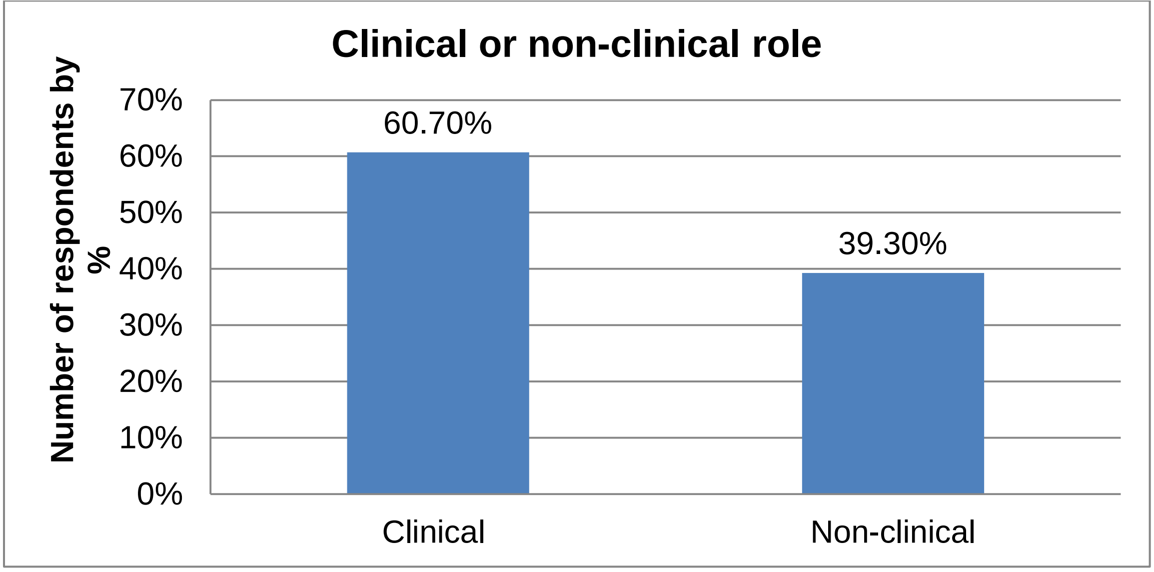


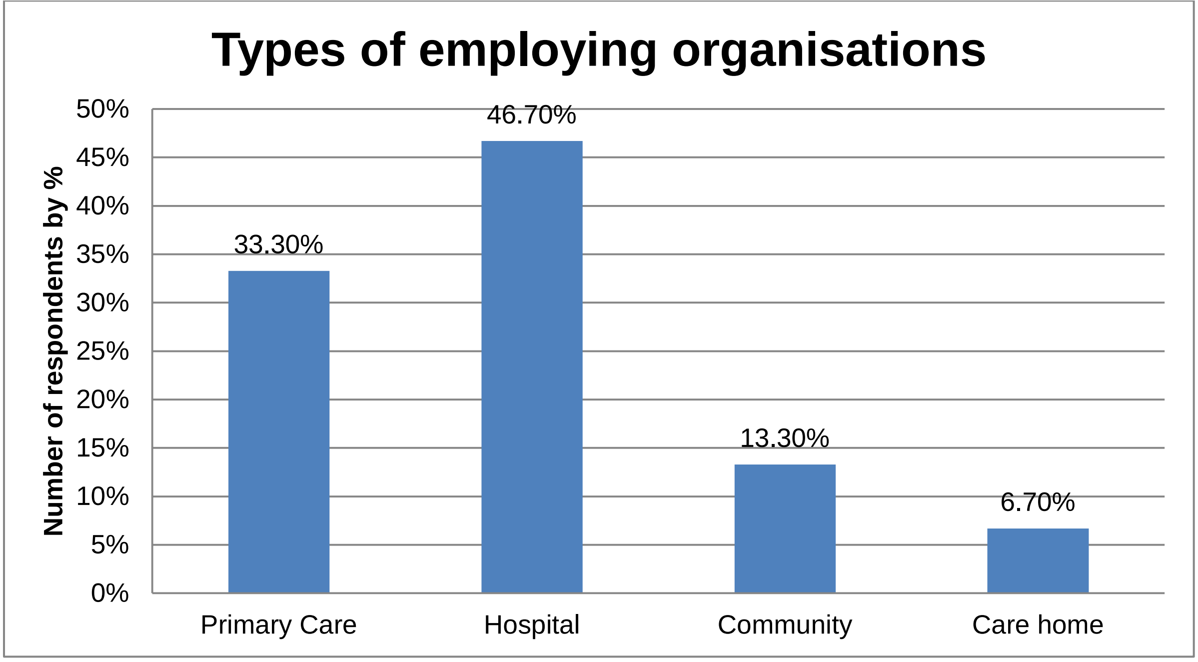
Figure 57: Breakdown of participants with a clinical or non-clinical role by percentage



Breakdown of employing organisations

Of the 30 responses received, most participants reported to work in hospital (n = 14, 46.7%) or primary care settings (n = 10, 33.3%). The remaining participants worked in the communities (n = 4, 13.3%) or care home (n = 2, 6.7%) settings. The results are displayed in Figure 58.

Figure 58: Types of employing organisations



Contact with clients

Of the 21 responses, majority of the participants (n = 18, 85.7%) have face-to-face contact with patients/clients (Figure 59). Twenty three out of 30 participants (76.7%) also reported to have regular contact with people with dementia (Figure 60).

Figure 59: Participants with or without face-to-face contact with patients/ clients by percentage

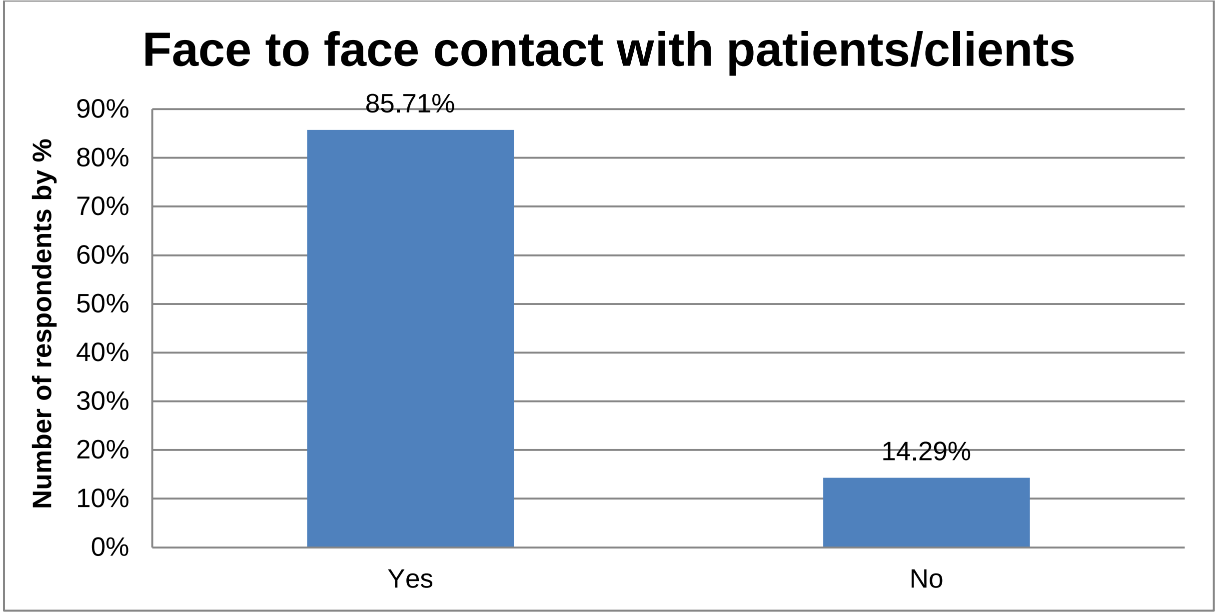
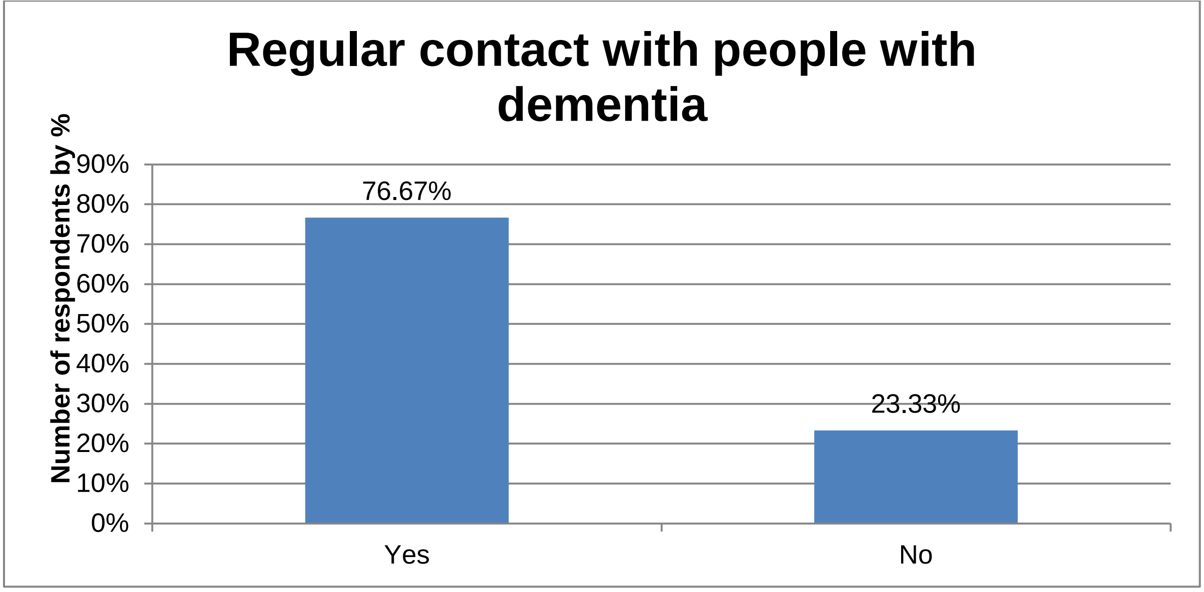


Figure 60: Participants with or without regular contact with people with dementia



24.3.2 Outcome measures

The results on the outcome measures from the six weeks follow-up interviews are discussed in the following section along with the qualitative results collected from the immediate evaluation and six weeks follow-up questionnaires.

24.4 Essential themes

The open-ended questions in the evaluation forms and the six weeks follow-up interviews provide further insight of participants' experiences of the dementia training and the overall impacts of the training on participants and organisations. By incorporating the qualitative data from the immediate evaluation and six weeks follow-up, the following section uses the five elements extracted from the data to evaluate the training on its quality, impact and value:

- Training quality
- 'Three things learnt' and impact on job role

- Changes in confidence
- Facilitators and barriers in translating training to practice
- Values of extended training and any other additional training needs

3.4.1. Training quality

In the six weeks follow-up evaluation, participants were asked to comment on the training and indicate anything that they would like to add or omit from the training. The feedbacks received were generally positive and most participants indicated that there is nothing that they would like to add or remove from the training. Of those who have given comments and suggestions, their responses are discussed in the following subsection:

- Training content and delivery
- Feedbacks on trainers
- Videos
- Multidisciplinary approach

Training content and delivery

Overall, the comments received for the training were predominately positive. Many participants reported to found the training session very enlightening and informative.

‘It opened my eyes because I like to get to know a bit more about dementia, so I can have an understanding when dealing with residents who suffer from dementia, especially with all the different types of dementia that is out in the field.’ (Senior Care Assistant)

‘All the feedback that I got from staff was really positive, they were very pleased that they’d attended and very interested in doing similar training again because it made them understand situations and people much better and would help them going forward in their own job or actually, just in their personal life.’ (Practice Manager)

Participants also commented that the length of the session was just about right to cover the basic information and allow people to take time off from their daily duties.

‘I think it was about right. It ran to time. There was time for questions at the end, so I think, and I think 2 hours, once you’ve got over 2 hours, it’s very difficult then for people to attend, it gets more difficult and also people’s concentration spans begin to wane as well.’ (Head of Risk and Clinical Governance)

However, some participants felt that the there was a lot of information covered in the training and suggested that more time should be allocated for the training to facilitate discussions and sharing of experiences among the audiences.

‘I don’t think it was long enough, because it was great to hear like experience of what other people have gone through and obviously you could use what you learned from that person in your own situation, if you came up with that problem…you didn’t really have a lot of time because there was so much to cover in such a short space, you couldn’t get to know everybody’s experiences.’ (Healthcare Assistant)

‘There was a lot of content absorbed, there was a lot of feedback and questions from the group I was with. So I think it could have done with being longer… The style of it was a little bit, what do you know about dementia and asking us things. And I think because of the time restriction for the group, it would have been better if we’d just been informed of things, rather than make it an open discussion ‘cause I think that sort of slowed things down and so we didn't have as much time with other areas… So I think the structure either needs to be longer to accommodate that sort of open question section or get rid of that open question section.’ (Physiotherapy Admin Team Lead)

The dementia training was delivered to a range of audiences from experienced practitioners to novice non-clinical staff with minimal experiences with people with dementia. However, the evaluation results demonstrated that the training resonated with majority of the participants with different backgrounds and expertise.

Among those participants with limited contact with people with dementia in their job role or personal lives, they have indicated that the training was an eye-opener and their understanding of dementia have increased as a result of enhanced knowledge on the impact of dementia on the individuals and their support network.

‘I think it was very informative, it applied to our jobs, because I think you showed us a video of a gentleman rocketing up at the surgery and couldn’t remember why he was there. I think mainly awareness, and how it impacts on the individual, families, communities, the roles of clinicians and other members of staff in the organisation, whether it is a surgery or a hospital.’ (Medical Secretary)

‘I thought it was very good training. Yes, excellent training in fact, because I wasn’t quite as aware of dementia as what the course made me, of how many different types there are, even though I work in that environment and I do type up the clinical letters. It also gave me an insight into what actually causes a lot of the problems for these people and how to react to them. It’s OK seeing a description of something but when you actually learn all the different types of dementia, it really helps.’ (Admin Assistant)

‘I think it was very good and simple things that I hadn’t thought of because I really don’t have much experience of dementia. I’ve always been with physically ill patients. Things like changing the colour of the handles in the disabled loo and things like that, to show up colours to try and make sense of it, things like that, you know, really practical things I thought were very interesting and useful. And I thought the whole day was very informative.’ (Outpatient Sister)

Some participants with minimal contact with people with dementia in their job role also expressed surprises that the training was made relevant to them and it has prepared them to assist individuals with dementia in their daily encounters.

‘I think we get so absorbed with being in our little maternity bubble that actually, year, you might be walking past someone in a corridor and they might be confused, or, it was just really interesting to have an insight into it and see how, even if we’re not directly in contact with them, how potentially we can help.’ (Newly Qualified Midwife)

‘It doesn’t necessarily, you know, directly relate to our role, you know, I still think that, you know, to do it is good, to raise the awareness because of, you know, the increasing issues that, the increasing number of people that are being affected by dementia.’ (Health Visitor)

Throughout the training and in the evaluation, many participants have disclosed that they have personal contact with people with dementia. Most of these participants have reported that the training have given them an insight on how their loved ones were feeling and provided them with practical suggestions in assisting and taking care of their families and friends with dementia.

‘I found it very enlightening, one reason being partly my job and partly because I have a close relative who’s been diagnosed with it. So I found it very, looking at it from their point of view, which I’d kind of really not considered before, really just how we deal with it from our side, so it gave me a bit of insight into the actual sufferer from that condition.’ (Reception Manager)

‘I really enjoyed the training, because my father-in-law was diagnosed two years ago with Alzheimer’s disease, and I lost my mum about a year ago and she had dementia as well. So, I found it gave me a much better understanding of what my father-in-law is going through and it gave me some information that I have actually gone back and shared with my husband and my mother-in- law. Things that help us to understanding the difficulties a bit better, the difficulties he is having now.’ (Secretary)

Feedbacks on trainers

The responses received in regards to the trainers were predominately positive. Participants praised the trainers for being very knowledgeable and passionate about raising awareness on dementia. They also reported to have enjoyed the training and that the trainers have made the training materials very easy to understand for all audiences. Participants were also impressed with how the trainers facilitated the discussions and managed audiences’ emotions following the videos.

‘…[facilitator] was great, she put it across brilliantly, it was easy to understand as well, so it wasn’t too technical, too medical, but everybody would know what she was talking about.’ (Healthcare Assistant)

‘I thought the training was brilliant actually, I thought it was really good, the person who led it was very, she was a great speaker and really listened and got us to listen and to air our views.’ (Practice Nurse)

‘The trainer herself was very good and she gave everybody time to think and have individual questions asked and answered.’ (PALS Officer)

‘The trainer I thought was excellent. I came away feeling she delivered the training in a very professional way, it was quite an emotional experience but she dealt with it in a particular way which I really admired her for, in that when we had a video and it was quite sad and quite emotional, seeing what was happening, she gave us time to digest that afterwards with just a minute or so of reflection but then she picked the group up again and introduced some humour, without making it feel derogatory to what we’d just seen. Very, very professional.’ (Superintendent Radiographer)

Videos

The videos shown in the training, especially the ‘Barbara’s story’ was cited frequently among the data collected from the immediate evaluation and six weeks follow-up. The videos depicting a fictitious person’s journey of living with dementia have created imageries of the lived experience of individuals with dementia and have made significant emotional impacts on the participants.

‘The film we watched was very thought provoking and I would say quite a few people had a few tears, so I think it gave the emotional punch that helped get the message through.’ (Practice Manager)

‘I mean I remember being there and most of the women that were there got very upset with watching the video but there again, that is part and parcel of life, but you don’t actually realise it until you actually see it there in front of you, so it was quite upsetting to watch, but also it was very good to watch as well…. The video content kind of just helped you understand it more and see it, as I say, you know, from the patient and the relatives’ point of view that was being shown how they dealt with it.’ (Reception manager)

Some participants also expressed appreciation on the use of blended learning approaches with the use of videos in supporting the delivery of the training materials.

‘It did certainly make you think about scenarios and situations.’ (Office Manager)

‘… I think adding the videos in the training really helped.’ (Assistant Practitioner)

Although the videos might have made a lasting impact on participants and probed discussions on the experiences of individuals with dementia, some participants were concerned that the videos might have emotionally exhausted the participants with families or friends with dementia and created negative emotions within the audiences.

‘It was very emotional and there was a couple of people in the room, myself included, had personal connections to people with dementia and poorly people and the families, so it was quite hard for some of the staff.’ (Office Manager)

‘…some people found that quite emotional and some of the clinicians thought it may be went on a little bit too long.’ (Practice Manager)

Multidisciplinary approach

A few of the participants appreciated the use of multidisciplinary approach in involving both clinical and non-clinical staff in the training as it promoted inter-professional learning and allowed participants with and without experiences with dementia to exchange information and practical tips.

‘Yes, that was really good as well because obviously, being a healthcare assistant and then you’ve got even sisters and specialist nurses there as well, so you get to hear their experience and they were quite interested in your experiences, which obviously in the job you don’t really get to spend a lot of time with the hierarchy, so it was quite nice to share all experiences together.’ (Healthcare Assistant)

‘…the mix of clinical and non-clinical was very good because it raised different questions from each side that everybody could learn from.’ (Practice Manager)

Some participants also felt that the use of multidisciplinary approach have given them an opportunity to network with other staff and provide a more comprehensive understanding of people involved in the care of the people with dementia.

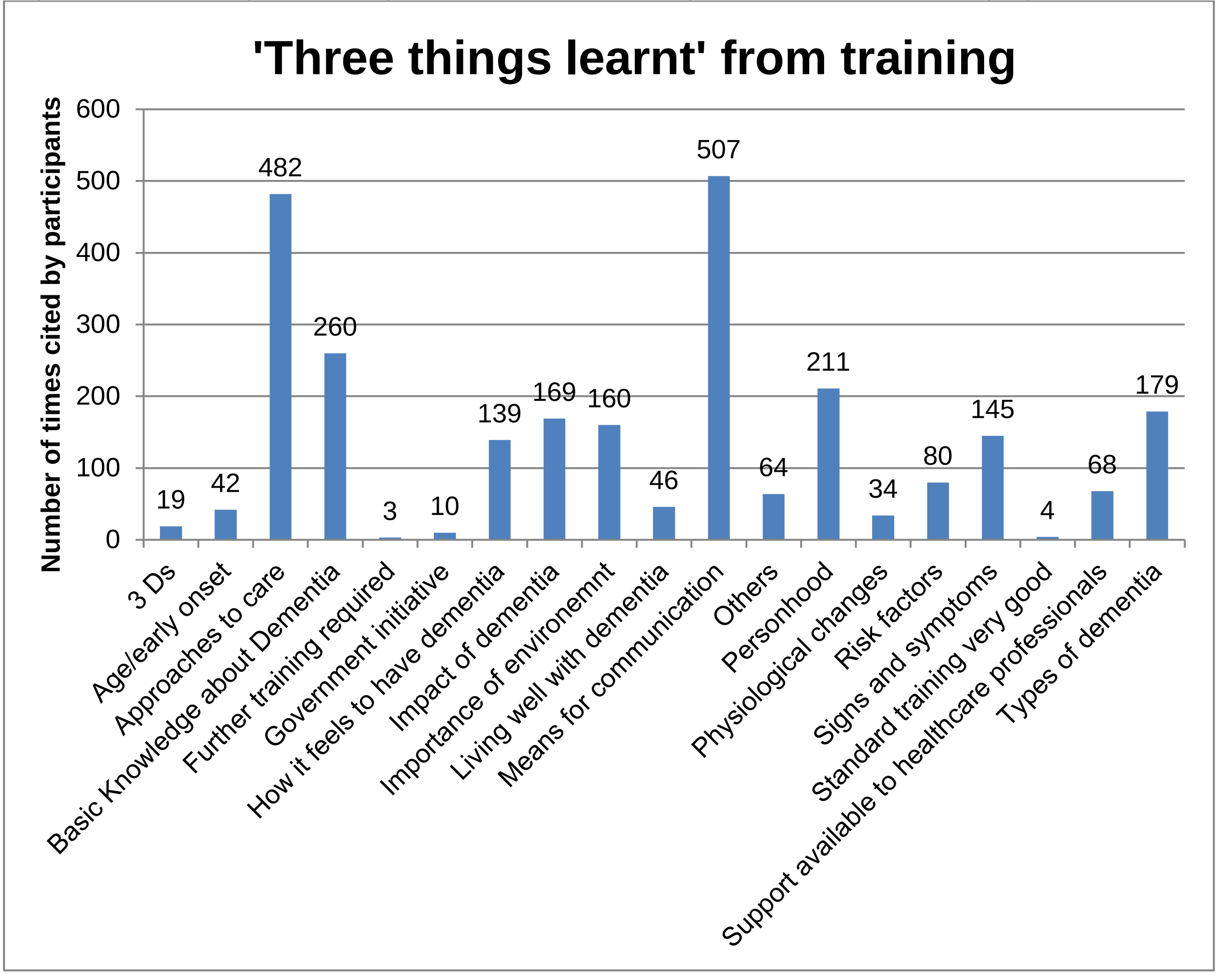
‘…because you heard about other people’s experiences which was really good, it was good as well for networking purposes.’ (Superintendent Radiographer)

‘To deal with people with dementia, you do need a multidisciplinary approach, you do need people from various perspectives, especially I was of that idea before the course but during the course, we were different setting people, there were nurses, there were people from the community and actually, I could see the different challenges for different professional roles. It is not only the burden for the patient that has the dementia, for the personal health of the patient who has the dementia, it is also how the network around how this person works. So you do need various professionals to be able to assist the family and the person with dementia. It is not enough to be one doctor or one nurse, you still need the physios, you still need the occupational therapists for later stages.’ (Consultant Geriatrician)

24.4.2 ‘Three things learnt’ and impact on job role

At the immediate evaluation, participants were asked to identify three things that they learned from the dementia training. Two thousand six hundred and twenty two free text responses were received and the responses were coded into themes as displayed in Figure 61. As demonstrated in Figure 61, ‘means for communication’, ‘approaches to care’ and ‘basic knowledge about dementia’ were the three areas cited most by participants as ‘three things learnt’ from the dementia training. These three themes were linked to the core requirements of the dementia training programme as described in the Phase 2 report and supported that the training has achieved its objectives in introducing and expanding the knowledge about dementia in healthcare providers participated in the project.

Figure 61: Participants' responses on 'three things learnt' from training by themes



In the six-week follow-up interviews, participants were asked whether they have been able to apply knowledge gained from the training to their job role. The responses obtained are discussed with the themes presented in Figure 29 in the following subsections:

- Means for communication
- Approaches to care
- Knowledge about dementia
- Personhood
- Environmental adaptation
- Situational awareness outside workplace

Means for communication

Among all the free text responses received, 507 responses was categorised under 'means for communication' and it is the area that was cited most frequently by participants in related to 'three things learnt' from the dementia training. As indicated in the free text responses, some participants were able to identify ways to improve their communications with people with dementia:

- Spend more time to listen and communicate
- Avoid asking too many questions as that might overwhelm and confused people with dementia
- Relate to the VERA framework on how to interpret communication and provide compassionate responses to people with dementia.
- Aware of the impacts of non-verbal communication, e.g., positioning themselves at the eye level of the people with dementia when communicating with them

The above key elements in communication were also indicated in the six weeks follow-up interviews as participants provided several examples on how they have adopted the communication skills learned from the training in their job role. This is a key learning outcome as the training has made participants aware of the ways in which their communication skills could improve and participants were able to illustrate the steps in adopting the learned communication skills in their job role.

‘The dementia patients that we’ve got, I mean most of them kind of come with a carer or somebody with them so, but generally just being more understanding of their needs if we’re speaking to the patient. If I’m ringing up to get them to come in, you know, if I find that they’re not understanding me then obviously we make sure now that we have more contact details for people that are around them so that, you know, if we do want them to attend for specific appointments that, you know, they don't miss them and they don't get upset about missing them and things like that. So we usually have like a carer or a next of kin definitely to contact to, you know, reiterate that we have booked an appointment for the member of the family.’ (Reception Manager)

‘One of the things that for me, was when I'm speaking to a patient with potentially dementia and they’re often on a trolley or in a difficult position because they’ve come in as an A&E type of patient, you do tend to lean over them face-to-face to ask them basic questions like what’s your name, when were you born and we do tend to ask those in quite a demanding way, which could be quite scary to that patient and I'm very conscious now of how I do that and I try not to lean over the trolley, I try to get down so I'm on the same eye level with them and speak to them in a slower fashion as well, because they can’t remember it all. So that was one thing that I really did take away and I practise now all the time.’ (Superintendent Radiographer)

‘Yes, especially because I was saying when I went on the actual course, we had a gentleman who was on the ward, who was asking about payments and he wanted to pay for everything, so I got some tips to help him understand that he didn’t have to pay for his treatment in hospital, didn’t have to pay for his food, so that was quite good and I was able to use those tips that I got told on the course, so that was great.’ (Healthcare Assistant)

Approaches to care

Following to ‘means for communication’, ‘approaches to care’ was the second most cited area by participants in regards to ‘three things learnt’ from the training. The free text responses provided an overview on how staff were more aware of the impacts of dementia and the approaches they would adopt in providing care to people with dementia and creating a more dementia friendly environment in their workplaces.

Within the 482 free text responses received, there were several key words that were mentioned by participants:

- Compassion
- Patience
- Empathy
- Understanding

These four key words summarised the impact of training on staff's approaches in caretaking people with dementia and provided evidence on the increase in knowledge and understanding of staff on how to provide quality care to people with dementia. It was also mentioned in the six weeks follow-up interviews that several participants were more aware in recognising signs of symptoms of dementia and more confident in their ways of engaging with people with dementia.

'I think so, yes, because when I meet patients face-to-face, I understand how to approach them, which sometimes I don't think you do until you actually learn about dementia. You don't realise how much these people are struggling with their memory and, but they're actually scared. You know, you just think of them as being not completely with it, shall we say. But, and you know that it's called dementia but when you understand how it affects them, that they can't actually cope with things, I think that's easier to make me understand how to help them. How to react to them when they come in to the clinic.' (Receptionist)

'I think the main thing I brought back to our department is to spend more time with patients. As a Trust and in general, we're always conscious of time management and turnover of patients and the public we're dealing with, but it can be so crucial, that first conversation you have with a patient with dementia, I've sort of slowed things down more and I'm taking more time to assess the patient's needs. And it's just those little subtle things that you pick up on, I sort of pick up on now, that you notice if patients are confused, not really sure of why they're there or what's going on. So I think it's made me more alert with things like that.' (Physiotherapy Admin Team Lead)

'Yeah, I do actually, I think I can see more from the patient's side, rather than just the nursing side. I can think about what the patient might be going through, from the videos we watched to understand why sometimes they cannot do what you are asking them to do.' (Assistant Practitioner)

Knowledge about dementia

The third most cited themes of 'three things learnt' from the dementia training was 'basic knowledge about dementia', with 260 free text responses received (Figure 61).

Along with this theme, there were more than half of the themes extracted from the 'three things learnt' question were related to the general knowledge about dementia and covered majority of the core requirements of the dementia training package. These themes included the '3 Ds', 'age/early onset', 'impact of dementia', 'risk factors', 'signs and symptoms' and 'types of dementia' (Figure 61).

In the six weeks follow-up interviews, some participants have given examples on how they have applied their knowledge about dementia to their job role. Some participants indicated that they have greater awareness on dementia and better understandings on the behaviours exhibited by individuals with dementia as a result of enhanced knowledge of dementia following the training.

'Well I think one of the things here that I said, I think we are quite good at being quite proactive. So staff will pick up on and let me know, this is kind of usually how I get involved, when they say, oh this patient's turned up today and they didn't have an appointment and, you know, we've seen her before and she doesn't normally seem that confused. And they always put an alert or a message on the notes and we let the GP know. So I think we're already quite good at doing things like that, 'cause the reception staff see the patients possibly more than the doctors do as a group, so the fact that they share that sort of information and show their concerns, I think we're very good at that here. And I think just in general, it was just the way you speak to patients that are either known dementia or their behaviour shows that there could be a problem, sort of like learning how to, you know, well hopefully reminding people how to speak to people. And also the fact of the age, that it's not necessarily just older people. So I think that was just things here that staff took away with them. And although we haven't changed anything, that was quite a big thing that staff picked up on.' (Office Manager)

'As I say, the layout of the building which is confusing for people sometimes that don't have dementia, the reception staff have taken on board what they learned during the training, when they're dealing with patients that may present who are confused or unsure of where they are. We also hold a Memory Assessment Clinic here, which we were doing anyway but again, those patients are, the reception staff have a better understanding of maybe some of the behaviour of the patients that are attending that clinic as well.' (Practice Manager)

'I had to visit a gentleman shortly after that training where I'd been asked to go by the ward because he was unhappy about something and I [inaudible] some of the things that I, was covered in the training to see whether or not I thought that dementia was part of the issue and I felt after the training I'd had, I felt that he wasn't suffering from dementia, there were other contributing medical factors.' (PALS Officer)

Personhood

Personhood was one of the key focuses in the dementia training and was highlighted in the Phase 2 report and in the literature as one of the core elements in care delivery for people with dementia. As demonstrated in Figure 61, 'personhood' was the fourth most cited theme with 211 free text responses received. Further examination of these free text responses showed that participants were reminded of the idea of personhood and its role in providing person centred care for people with dementia. Some of the participants' responses focused on treating people with dementia as individuals with respect and dignity, getting to know the identities and life stories of people with dementia and understanding their individual needs. The above elements were also reflected in the six weeks follow-up interviews when participants described how the training had influenced their practices.

‘And I’ve just been more aware of how to sort of like, you know, speak, so that you’re including the person with dementia. And not just talking about them as a, you know, well I’m not like that anyway, but do you know what I mean, not, you know, just so that, because, obviously, they’re still a person and just because they’ve got dementia doesn’t mean to say that, you know, they shouldn’t be included in these assessments. So yes, it’s made me more aware of taking into consideration and understanding their problems.’ (Carer Assessor)

‘I think a big part of it was the whole, I’m still a human, this is me, please don't treat me... I think it is horrible and it is natural to sort of go into stereotype of how you treat someone once you hear of it, which I know we should try and avoid. But if you're not used to it, then I think you naturally go into that sort of role. But I think it’s definitely opened up that, it sounds really bad, but the fact that they are still human, they are still a person and treat them as a normal person, don't try and baby or belittle them, they’ve still got their independence and their dignity.’ (Newly Qualified Midwife)

Environmental adaptation

As highlighted in the dementia training and Phase 2 project report, any environments can be modified and adjusted to be more dementia friendly. From the immediate evaluation, a total of 160 responses related to the importance of environment were cited by participants. Few participants have provided examples on how they would incorporate colours and contrasts in aiding the sensory perceptions of the people with dementia. For instances, some participants suggested the use of colour plates and cutleries to improve nutritional intake for people with dementia.

‘Environment using colours e.g. red plate increasing food consumption.’ (Administrator)

A few of participants have also taken into account of the sensory hypersensitivity and poor sensory integration in people with dementia and have raised attention on how their practices would make people with dementia feel.

‘How noise level and bright environment can be so distress.’(Radiography Practice Educator)

‘How to help people with dementia e.g. reduce noise, reduce bombarding with questions.’ (Physiotherapist)

Several participants also suggested the use of signage in highlighting important objects and orientation points to promote independence and avoid confusion in people with dementia.

'The things like, when I've seen carers and they're saying things like, oh, you know, so they've gone to make a cup of tea and, you know, have to stop them from doing that because they don't know where the, you know, where the cups are anymore and don't know where this, that and the other is. I've said to them about labelling cupboards, so that, you know, they care for, the person, you know, doesn't have to remember, they can actually read where things are. So that kind of thing.' (Carer Assessor)

As mentioned in the six weeks follow up interviews, some participants have started incorporating some changes and adjustments in making their practices more dementia friendly since the training.

'Well I think, well basically that was useful because we are quite a dementia friendly practice, so we had some little changes in our practice entrance, you know, pictures, photographs to make just more [inaudible] dementia or their carer and so...' (Doctor)

'Personally, I am about to refurbish two of our treatment rooms, so I am looking very hard at the colours of floors because I've been made aware that like a blue floor to somebody with Alzheimer's is often like water to them, therefore they don't want to tread on it.' (Surgery Manager)

'I've reviewed – because I manage the building, so I've reviewed our building and we've looked, I've got all the bits here right in front me, we're actually having a new signage put up, we're having different things which were basically very simple things but nothing is simple until it's pointed out to you. Changing the colour of the toilet seats, having dementia friendly colours/signages put up, we have a very long corridor so myself and two of my staff have walked around on different occasions, the clinical staff have given me feedback of, "if you were a patient that had dementia and you were looking for the exit, is it obvious?" So we don't think it is, we're investing in new signs so that it becomes obvious then. That's how I've applied it to my workplace.' (Practice Manager)

Situational awareness outside workplace

Although this category was not mentioned in the free text responses received for the 'three things learnt' question in the immediate evaluation, it was cited by a few participants in the six weeks follow-up interviews that they were able to extend their knowledge about dementia to their personal lives and in the communities. This highlights the impact of the training in raising awareness and professional knowledge and its additional values in reducing sigma and isolation in the communities. It also indicates that the training content was able to made relevant to staff and gained interests from them to translate knowledge to practice.

'…when I am out and about I would probably me more likely to become involved, because when you don't know about something you tend to stay away, don't you? I would probably more likely to offer assistance or something and not be frightened and not feel as out of my depth.' (School health assistant)

‘It’s maybe where you come across people in a shop or, you know, walking down the street that you don't know and then, you know, something, a little spark in your mind takes you back to that course and then you might treat them a little bit differently and be a little bit more patient and a little bit more understanding, because you think, well I don't know, maybe this person doesn't seem, you know, completely on the ball.’ (Medical Secretary)

‘I’ve started applying it to elderly relatives, some of the information that I fed back from that, is starting to give me more sort of awareness of their requirements. So I think it’s just a general noticing more and being more aware.’ (Physiotherapy Admin Team Lead)

24.4.3 Changes in confidence

As documented in the literatures, individuals’ confidence in providing care to people with dementia is linked to their knowledge and attitude on dementia. Following the training, majority of the participants indicated in the six weeks follow-up interviews that their confidence in working with people with dementia has changed as a result of the training. Some of the participants mentioned that the training has increased their knowledge, understanding and awareness of the condition and hence, they felt that they are more capable in caring for people with dementia and their families.

‘I know can understand some of the anxieties that the families may have and I feel more confident in talking to them and to try and understand the problems from their point of view as well.’ (Assistant Practitioner)

‘I think yes, I think so, like I say, we have one to ones normally if we’ve got dementia patients because I work on a busy wards, so it’s difficult obviously to keep the care of dementia patient all the time because they're a lot more vulnerable to the other patients, but if we have to cover the breaks and stuff like that, I feel more confident in myself being able to look after that patient without getting myself stressed, which obviously would mean stressing the patient out, so I do think the course has made me understand a bit more about what people with dementia actually go through.’ (Healthcare Assistant)

‘Yes I do because the examples given on behaviour have given me a better understanding and I know the feedback from my reception team and to my nursing team, again they had that as well, the fact that there was some behaviours, certainly during Barbara’s story, that she displayed or [that the Facilitator] explained to us why people might be behaving in the way that they are is because of something else that isn’t obvious, so it just brings, makes you more aware of that. I think unless you're dealing with people every day then I think, well the more you deal with people, the more confident you become but I certainly feel that the training gave me the tools and the information to sort of have a better understanding of working and dealing with dementia patients.’ (Practice Manager)

On the other hand, some participants believed that the training has validated their existing approaches to people with dementia and continued to promote their good practice in providing quality care.

‘Yes, as I just described, as I say I have a fairly calm, warm approach with people like that and this is nice to have it validated as useful, like for example, if somebody was talking about their mum and that was clearly a fantasy, that you wouldn't start saying, “Oh yes, [I saw your mum earlier]” or something like that but at the same time, it’s not loving to say “You know your mum’s dead”, it’s maybe useful to ask something about their mum or use some distraction to talk about something that is happening, not belittling the person.’ (Registered Nurse)

‘As I say, personally, because I’ve already got quite an awareness of it, it was just nice to have it confirmed that hopefully I have in the past said the right things, you know, not correcting, going along with it, that sort of information. So yeah, it’s quite nice to hear that.’ (Office Manager)

Several participants also agreed that the training provided opportunities for them to reflect on their own practice and highlighted things that they have not considered before the training.

‘Yes, I think so. I mean without wishing to sound complacent, I have had quite a lot of experience, you know, personal and at work. But I think it did, it was a, yeah, I think I learnt stuff that I hadn't realised before or it hadn't clicked with me. I mean I can remember with my mum, taking her to, she’d had a fall and thought she might have broken something so she ended up in A&E which is an horrendous experience for somebody with dementia ‘cause you’ve got all the noise going on. And I hadn't, I mean I’d remembered that, but I hadn't really sort of applied that in other circumstances, so it’s a reminder that that wasn't, you know, that wasn't unique to my mum. Lots of people with dementia suffer that horrible feeling of being overpowered by noise and people and not understanding what’s going on.’ (Medical Secretary)

‘…it’s just like something you highlight things again for you, you reflect things again and you see things maybe from different aspects. But you know, somebody you know, you have somebody, you’ve seen them before but you look at it from a different way, so I think yeah, I don’t think it maybe told me something I didn’t know completely but it just highlights certain things …a motivating process to make you again look at your practice in a different way, improve, develop, you know, bring different experience to your practice, yeah, I think so, yeah.’ (Doctor)

As mentioned in the previous subsection, several participants have disclosed that they had personal contact with individuals with dementia and they were able to translate the knowledge learned from the training in caretaking their closed ones. Some of these participants have also indicated that the dementia training has increased their confidence in providing care to their families and friends with dementia. This demonstrated that the impact of dementia training does not limit to the participants’ workplace but can also extend to their personal lives.

‘Yes, definitely. As in my work and the member of the family that suffers with it as well, so yes, it’s made me a lot more comfortable of being around her and actually dealing with people like that. I have more time for them, understanding and yes, definitely.’ (Reception Manager)

‘I’m able to speak to my relatives about it as well…Because I have a family member who is currently suffering from dementia and also, a friend of a friend, who’s suffering from dementia. And, of course, I’m able to say to them, well have you thought about this, have you thought about that? You know, what type of dementia is it? You could get help for this, that and the other and you need to contact this person.’ (Admin Assistant)

Although majority of the participants indicated that their confidence level has changed since the training, a few of the participants reported that they were already equipped with knowledge about dementia prior to the training and that the training did not change their confidence in providing care to individuals with dementia.

‘Probably not from that point of view, because obviously, as I said, being clinical by background I have that element of experience and clinical sort of confidence.’ (Head of Risk and Clinical Governance)

24.4.4 Facilitators and barriers in translating training to practice

In the six weeks follow-up interviews, some participants were asked to identify any facilitators and barriers that help or hinder them in putting training into practice. Most respondents stated that there is not any specific facilitator or barrier. However, of those participants who did identified some facilitators and barriers, a few elements were extracted.

In terms of facilitators, most participants agreed that a buddy system and/or personal development plan would be helpful in facilitating transferring training into practice on an individual level.

‘…personal development is the most important because everybody’s different and everybody reacts differently to looking after patients like that and if you are more informed and do have more experience with dealing with people with dementia, it’s a lot easier but I think if you first come into the Trust or it’s your first experience with dementia patients, it’s very difficult to know how to make their experience better and how to look after them without getting yourself worked up and the patient, so the course, with the personal development, it helps you develop yourself.’ (Healthcare Assistant)

A few of the participants also suggested shadowing or sharing of experiences within practices as ways in facilitating participants in transferring training to practice at an organisation level.

‘Yes, I think if, as part of the training we also had the availability to do something like shadowing a [inaudible], that would be, you actually get, you know, real life, hands-on experience of it. And I think when you’ve actually seen and experienced something, it sinks, you know, more into your psyche than actually just sitting in a class [inaudible] about it.' (PALS officer)

'Well for some practice, you know, the younger, I think that some practices, that are sort of more of a young demographic population and then they don't have much contact with dementia, so they're less of elderly people, less of dementia, so, and their experience would be less. Where I think here we have more elderly patients at [town name] area so I think we'd be, even staff would be more contact with... [inaudible] more experience with [inaudible] with dementia compared to other practices. So they can feedback [inaudible] could be good, you know, like a local meeting be arranged around dementia, you know, would be, probably might be beneficial, yeah.' (GP)

More importantly, many participants reiterated the importance of the dementia awareness training and suggested that the training should be a part of induction for all new staff.

'Dementia training as part of the induction, 100%! Maybe you don't need that for the paediatric ward staff because Paediatric Doctors and Paediatric Nurses they don't have to deal with these kind of people or in Gynaecology, but 100% for all the rest, surgical and the medical divisions [inaudible 00:16:50] outpatient clinics and everybody needs to have a dementia training as part of their induction. It needs to be part of the mandatory training.' (Consultant Geriatrician)

'I think some part of this training should be incorporated as some sort of mandatory training 'cause again, it's just offering the training there for people to go to and not everybody will chose to go to it, either personal or job restrictions. And I think there's some vital information that they feedback in it that I, particularly ward-based people should be aware of.' (Physiotherapy Admin Team Lead)

'Yes, definitely. I mean I actually made it almost a mandate for all of the staff that I manage to attend and most of them are non-clinical roles, but by nature of what they do and the fact that it's very much out there, even when you're just walking round the hospital you might meet a patient that has got dementia. I felt that it was beneficial to all of them. And I think, yes, having every member of staff in the Trust trained at, I agree varying levels depending on what job they do, would be an excellent idea.' (Head of Risk and Clinical Governance)

In terms of barriers, most respondents indicate that one of the major barriers to using what they had learned was their limited contact with people with dementia. This is also evident in the six-week follow-up questionnaire results in which most participants mentioned that they do not encounter people with dementia on a day-to-day basis and hence, have not been able to apply training to job role. Other barriers identified by the respondents were time constraints, workload and lack of support from management. These barriers were inter-linked and mentioned in the Phase 2 report that many organisations had problems of releasing staff to attend the training as a result. This highlights the role of employing organisations in encouraging staff to attend the training and accommodating the release of staff from their job duties.

'…there's time pressure…I think that's the main thing really for us, being asked to do too many things.' (Doctor)

'I think just the general Trust attitude is that time management and timescale…and it's not always appreciated that you're taking that bit of extra time and care with the patient.' (Physiotherapy Admin Team Lead)

'I think if management weren't fully, I think everybody should be told to go, it should be a mandatory thing that everybody should go on the dementia course because I think I learned so much just within a couple of hours, if it was a full day, who knows what you could have learned and there's a lot out there when you know, all the reports going on about cruelty in hospitals and not looking after dementia patients properly, if they have this mandatory training for dementia then some of these problems might not happen.' (Healthcare assistant)

24.4.5 Extended training and any other additional training needs

Extended training

In addition to the standard training which covered the basic information on understanding, recognising and interacting with people with dementia, some participants were offered to participate in the extended session, which covered additional information including the 3D's, Vera framework, the Mental Capacity Act, etc. Participants in the extended training sessions were asked to identify, if any, values that they feel they have gained from attending the extended training. From the twelve responses received, three themes were identified.

Few participants indicated that the extended training session provided a good opportunity for healthcare staff to self-reflect and promote good practice in staff.

'Brought Dementia to the forefront and me be reflex on how I treated patients in my practice and community.' (Practice Nurse)

'I always communicated well with people but attending this course has given me the confidence to know that the way I communicate is the right way.' (Community carer)

Some participants mentioned that the extended training had reinforced the idea of personhood as they were reminded of the impact of dementia on individuals and their families.

'This extended training taught value. Value you as a person and treat with respect and courtesy, be friendly approachable and maintain their dignity and privacy.' (Volunteer Healthcare Assistant)

'…to really understand how a person with dementia feels about them self and how they see themselves within society.' (Healthcare Assistant)

Last but not least, most participants felt that their confidence have increased as a result of the training.

‘I feel I gained more confidence when talking and interacting with people with dementia and trying to understand how they feel.’ (Healthcare Assistant)
‘Gives me more confidence and perspective in dealing with post op elderly confused patients.’ (Ward sister)

Other additional training needs
From the six weeks follow-up interviews, most respondents indicated that the dementia awareness training was adequate for their role and did not need any additional training to help them support people with dementia and their carers. However, of those who did identify some additional needs, few elements are discussed:

Some participants said they would appreciate more practical training sessions which cover approaches and practical tips on how to help people with dementia.

‘I think it’s how to deal with the patient, how to extinguish situations that arise. It’s very difficult with somebody who hasn’t got dementia, you can talk to them and they sort of respond to you but with people with dementia, they don’t really understand what you're saying to them so trying to communicate and get across what you're wanting to do, I think the communication is a massive part and that would be really good thing about training, would be how to communicate better with the dementia patient.’ (Healthcare Assistant)

‘I think I need more practical sessions on the approach of people with dementia because the approach can change with the rate of the dementia, with [quality] people and so on, this I would say is one of the things and actually, when you're discussing with dementia, for dementia, everybody knows more or less what it is, the difficulty that you can have as an organisation, as staff is how to approach because we are all humans, sometimes you just don’t have, you are tired, you don’t have the patience or you are in another, you have your own problems and whatever and to deal with a person with dementia, you need to be 100% present so we do need to know some techniques of how to approach these people, the theoretical basis of dementia I think most of the clinical staff has it already.’ (Consultant Geriatrician)

Some participants highlighted the importance of having refresher training to acquire updates on new information or new services available for people with dementia and their carers.

‘I think it would be useful to have some updates, not necessarily on an annual basis but maybe every couple of years, so whether that was in the case of doing the updates online or whether a training aid such as a video was produced that we could watch as a group session, just to sort of kind of remind ourselves of the challenges facing those patients, something like that I think would be useful… there’s always new services available or support available, so I just think something along those lines would be useful.’ (Practice manager)

‘Refreshers are always a good idea, I feel, ‘cause in our hectic lifestyles and everything you do put things to the back of your mind. So sort of maybe an annual or bi-annual refresher would be good.’ (Surgery Manager)

25 Phase 3 Conclusions

Overall participants evaluated the standard training package positively. Quantitative data provided information on who had received the dementia training and the impact of the training on the participants; qualitative data provided further insight of participants' experiences of the training and how they have transferred knowledge into practice. Training was delivered across all staff groups and included clinical and non-clinical staff from the organisations that engaged with the DAAG project. More than 50% of participants had not received any previous dementia training and therefore the programme facilitated the achievement of nationally set targets for Tier 1 dementia training.

The quality of the training and the use of a multidisciplinary and blended learning approach were perceived positively by participants. The training materials were considered to be highly relevant, with the use of video material having a significant emotional impact on participants' insight into the impact of dementia on the lives of individuals and their carers.

The immediate impact of the training on the knowledge and skills of participants indicated that there was a self-reported increase in the level of knowledge participants gained from the programme. Our analysis identified no significant differences between clinical/ non clinical staff or professional categories or employing organisations. Over 85% of respondents reported improved skills, attitudes and confidence in working with people with dementia following the training. Of note is that healthcare assistants and participants working in care homes reported higher levels of knowledge on several aspects of dementia compared to participants with other job roles and working in other settings. This is an interesting phenomenon, which might be worthy of further exploration. Research suggests that Likert-type scales may result in a reference group effect, where participants use a personal or cultural construct as a reference point for their responses (Peng *et al.,* 1977; Biernat *et al.,* 1991). In initial discussions the DAAG considered the use of a knowledge test before and after the training but time constraints for the delivery of the training package meant that this could not be accommodated.

The response to the six-week follow-up questionnaire provided some insight into the intermediate impact of training. While the number of respondents returning the questionnaire was somewhat low (131 [12.4%]) of those who did respond 70.2% indicated that they had been able to transfer some of what they had learned in the training to practice. Those participants who indicated that they were not able to apply knowledge in their job roles identified that this was because they had not had any contact with people with dementia or their carers since the training event and hence, had not had any opportunities to apply their knowledge in their job duties. This is an important issue for employers as training is known to decay over time and has greater impact when participants are able to practice what they have learned in order to embed new behaviours.

Telephone interview respondents provided examples of how and when they would use what had been learnt; in addition they were aware of the impact of the training on their job roles and their personal lives. Most participants highlighted the importance of incorporating dementia training as part of an induction programme and emphasised the need for refresher events to update new information and services available for people with dementia.

Limitations of the evaluation

There are some inherent weaknesses in the evaluation of training programmes as they largely rely on participants' self-report of attitudes, levels of knowledge and skills. We are not able to attribute any link between the self-reported increase in knowledge, attitude and confidence of staff resulting in improved care of people with dementia. In addition, the low response to the six-week follow up questionnaire means we are not able to assess the ‘stickability’ of the training. While the use of a Likert-type response scale before and after a training event has greater rigour than a single post-training measure, it also tends to result in participants shifting their agreement one or more places to the right demonstrating a positive trend. It is also possible that those participants who had received no previous dementia training found the training more helpful and/or were more receptive to the content of the programme.

26 Project conclusions and future sustainability

As stated in the ‘Introduction’ to this final report, the increase in the incidence and prevalence of dementia has resulted in the need for major improvements in dementia care, training and health and social care policy and practice in the United Kingdom.

Recent government reports such as the National Dementia Strategy (2009), the National Audit of Dementia (2010), the Prime Minister, David Cameron’s, Dementia Challenge (2012) and the G8 Dementia Summit Declaration (2013) have all highlighted the need to improve the quality of dementia care provision in a manner that is cost effective yet easily accessible to all who may need it.

Such developments in health and social care policy mean there is a raised expectation that the health and social care workforce will be able to rise to the challenge of providing high quality dementia care. Whilst it is appropriate and indeed necessary for the improvement of dementia care delivery, it is essential for the health and social care workforce to be educated, informed and equipped to provide high quality care at whatever stage of the disease process.

It is against this background that the Department of Health issued the Delivering High Quality, Effective, Compassionate Care Mandate to Health Education England (DH, 2015a) stipulating that the NHS is responsible for ensuring that 85% of staff undertake dementia awareness training at Tier 1 Level and more recently Prime Minister, David Cameron’s, Challenge 2020 aims to ensure that all NHS staff are trained ‘on dementia appropriate to their role’ (DH, p.37, 2015b).

Responding to the call from HEE to ensure there is an effective workforce to provide care for people with dementia, proactive work across the Health Education England Thames Valley region has been taking place to meet HEE’s mandate. This positive action has been captured in this report by the HEE TV’s Dementia Academic Action Group, which was set up in January 2014 to deliver this two year, three-phase project to understand the delivery of dementia awareness training in the Thames Valley region and to support activities to meet the HEE TV training targets, as set out by HEE. Ultimately, the aim of the project was to undertake a scoping review to identify what dementia training was currently being delivered within the Thames Valley Region at Tier 1, with a view to informing the development of a co-ordinated approach to on-going and future dementia training in the region. This included a national and local policy review of dementia awareness training provision; and a stakeholder survey, staff interviews, carer focus groups to ascertain what was the structure, indicative content, and recommended delivery format for such training.

Completed in March 2015, the first phase of the project provided a picture of what training is being delivered regionally, what training support needs are for health care organisations and what issues are being faced in the delivery of dementia awareness training.

Phase 2 of this project, which ran from 10th May till the 11th December 2015, saw the development and delivery of one designed as ‘standard’, based on the findings from Phase 1 of the project and incorporating elements of Barbara’s Story, and one with ‘enhancements’ by four HEI facilitators to Acute Trusts, Community Trusts, GP Practices and Local Authority, Private Voluntary and Independent Sector organisations delivered to approximately 1,500 staff across the Thames Valley Region.

As the DAAG project was funded by HEE TV, the findings have been disseminated in oral and poster formats at the Health Education England Dementia Conference entitled, “Celebrating Thames Valley Quality Improvement in Dementia Care” held on Thursday 25th February 2016 at Kassam Stadium, Oxford. The “Development of a Dementia Awareness Training Package in the Thames Valley Regions: An Evidence Based Approach” was also delivered at the 31st International Conference of Alzheimer’s Disease International held in Budapest, Hungary in April 2016.

Designed to run alongside Phase 2 of the project, Phase 3 has contributed to the long term sustainability of the training, by evaluating the standard and extended training packages being delivered by the four trainers across the range of services using the tool designed by the DAAG in order to measure changes in knowledge, attitudes and confidence in dementia among participants who have attended the training. The intention for this phase was to identify factors which may act as barriers and facilitators to the transfer of knowledge gained in training to practice. During autumn 2015 and spring 2016, evidence collated by the team and the key findings from the feedback received from participants provided additional key information for the development of the DAAG training package.

The DAAG training package has been effective in raising awareness and knowledge about dementia; participants who took part in the training have also reported their skills, attitude and confidence in working with people with dementia has improved as a result of the training. Adjustment to the content and duration of the package to promote deeper learning and allow more time for interactions and discussion of the issues surrounding care of people with dementia would enhance experience of the training and possibly the incorporation of knowledge and skills into healthcare workers interactions with people with dementia. The DAAG team would recommend that employing organisations need to recognize the continuing importance of promoting and building awareness in the workforce of the needs and of people with dementia and not consider dementia training a ‘one off’ event.

26.1 Future directions

The central aim of this DAAG awareness (Tier 1) training project was to review what was currently being delivered in the HEE TV region with a view to informing the development of a coordinated approach to on-going and future dementia training in this area. To that end, the DAAG project team have reviewed both the availability of training resources in the region and local and national policy implications for the delivery of dementia awareness training; based on those findings, they have developed a training package which has been evaluated as ‘fit-for-purpose’.

The final phase of the project was to finalise the sustainable model for the delivery of Tier 1 dementia awareness training across the HEE TV region. Following the feedback from the stakeholder events, trainees during training sessions, the Phase 3 evaluation and the Phase 1 review, the DAAG developed the existing training into eight bite size units which could be delivered as a whole package (Units 1-6) or could be delivered individually.

Each unit was developed to be approximately 30 minutes in duration and encompass a variety of learning styles and formats, including: videos, discussion points and interactive learning.

The units cover the following topics:

- Unit 1: What do you know about dementia?
- Unit 2: What dementia means?

- Unit 3: Understanding the person with dementia
- Unit 4: How does dementia affect the person and those around them?
- Unit 5: Talking and listening to the person with dementia
- Unit 6: Supporting people to stay well
- Unit 7: Living well in society
- Unit 8: How to respond to behaviours that challenge

26.1.1 Train the trainer and online

A train the trainer programme with teaching manual and resources has been produced to enable organisations to deliver the training through peer to peer training. Units 1 and 8 have been designed to be delivered face-to-face as these units are the most interactive and learning from these units has been assessed as better suited to being supported by a trainer. This also builds on the findings of the project that face-to-face learning is the preferred style and also is thought to provide opportunities for inter-disciplinary engagement across staff roles and responsibilities, enhancing learning opportunities further.

However, an online version of the training has also been made available for those staff who are not able to attend a face-to-face training session but are still required to undertake Tier 1 dementia awareness training.

26.1.2 Core skills mapping

Since the writing of the Phase 1 report and the development of the training delivered in Phase 2, the Dementia Core Skills Education and Training Framework (SfH, EE & SfC, 2015) has been published, which formally identifies dementia training across three tiers and states the learning outcomes at each of these tiers. The tiers are defined as:

- Tier 1 – dementia awareness for all health and care staff
- Tier 2 – knowledge and skills for those who have regular contact with a person living with dementia
- Tier 3 – enhanced knowledge and skills for experts working with people living with dementia

More specifically, Tier 1 is defined as:

> ‘Raising dementia awareness, in terms of knowledge, skills and attitudes for all those working in health and care settings’
>
> (Skills for Health, p.11, 2015).

The Tier 1 learning outcomes, Figure 62, were used in the development of the updated training package to ensure it meets the current Tier 1 competencies. In addition to the learning outcomes, identified below, the principle standard of collaboration (using multi-disciplinary approaches to dementia care) has been associated with the delivery of Tier 1 training.

Figure 62: Learning Outcomes Tier 1

The learning outcomes for Tier 1 have been identified as:

a) know what is meant by the term dementia
b) be aware of the prevalence of dementia in the UK population
c) be able to recognise signs of dementia and also be aware that these signs may be associated with other conditions or circumstances
d) know what actions individuals can take to reduce their risk of dementia, or to delay onset
e) know why early diagnosis of dementia is important
f) know the actions that people affected by dementia can take in order to live as well as possible after diagnosis
g) understand the importance of recognising a person with dementia as a unique individual
h) be aware of the impact of dementia on individuals, families and society
i) be able to communicate effectively and compassionately with individuals who have dementia
j) understand reasons why a person with dementia may exhibit signs of distress and how behaviours seen in people with dementia may be a means for communicating unmet needs
k) be able to signpost individuals, families and carers to dementia advice, support and information.

(Skills for Health, p.13, 2015).

The revised training package has been mapped to meet the core skills and the following table shows the units and to which core skill they correspond:

Table 35: Training Units Mapped to Core Skills

Unit Outlines	**Core Skills Mapping**
Unit 1: What do you know about dementia?	A; B; C; K
Unit 2: What dementia means?	C; D; K
Unit 3:Understanding the person with dementia	G; K
Unit 4: How does dementia affect the person and those around them?	H; J; K
Unit 5: Talking and listening to the person with dementia	I; K
Unit 6: Supporting people to stay well	E; F; K
Unit 7: Living well in society	K
Unit 8: How to respond to behaviours that challenge	I; J; K

Units 1-6 cover all the cores skills and once completed meet the requirements of Tier 1 dementia awareness. Units 7 and 8 develop the ideas from the previous units and provide further information about living well in society and developing communication skills using the VERA method. These two units develop skills in preparedness for Tier 2 training.

26.1.3 Barriers to delivering training

Throughout this project, a number of challenges arose in relation to training delivery. These ranged from organisational pressures to practical issues of delivery. The range of barriers which were encountered included:

- Availability of suitable rooms
- Access to audio/visual equipment
- Staff availability to attend training
- Cost implications of releasing staff to attend training
- Cost of training attendance

- Understanding of benefits for the individual and organisation
- Competing training needs (e.g. mandatory vs. non mandatory)
- External organisations delivering within existing organisational structures

The DAAG worked flexibly with organisations in the delivery of training, working within existing organisational structures and trying to understand the pressures each organisation faced. In this way the team were able to overcome some of these challenges. The benefit of the training being free to access was a positive for many staff and managers and booking sessions in advance helped managers to plan shift times or to accommodate other staffing requirements. Advanced booking also meant that rooms could be secured for the training. However, as has been discussed, a number of the planned training sessions were cancelled due to lack of attendance.

Consideration of how to market training can address some concerns held by making it clear how the training meets professional development criteria or government mandates. This can also address issues of cost of the training and benefit to the individual and the organisation. Furthermore, booking sessions in advance can help in planning for room availability and release of staff from work. One final consideration from this study is that the DAAG did not hear directly from those who did not attend the training to understand their reasons. Such an understanding could support future delivery.

26.2 Train the trainer model

The Dementia Academic Action Group project, commissioned by Health Education England Thames Valley, has designed and delivered dementia awareness training under their mandate for all NHS staff to be trained appropriately for their role. Now, a Train the Trainer Package is being launched as the final stage of the project. During the project, four facilitators from the DAAG have delivered 80 sessions to over 1,400 professionals across the health and social care workforce. Sharing a Train the Trainer package enables the on-going delivery of Tier 1 Dementia Awareness training and ensures that staff can continue to access it. This gives the health and social care workforce, including administrators, cleaners, doctors, nurses, porters, and therapists further opportunities in the future to train, free of charge.

The training packages created by the team, have been further developed to support their delivery by a new cohort of trainers who have expressed an interest in delivering the training. It is recommended that these future trainers are individuals with a responsibility for development or working in a training role within their organisation and we have suggested that they should have some experience with working with people with dementia. The modifications which have been to the programme have been based on the feedback from the original facilitators, as well as the evaluation data from the third phase of the project. The team have ensured that:

- The training meets the core skills set out by Skills for Health in Tier 1 and provides a solid foundation for those wishing to progress to Tier 2.
- The package is also deliverable in a flexible format which can be tailored to staff and organisational needs.
- The full version of this training has been endorsed by Alzheimer's Society as meeting the standard requirements for the Dementia Friends initiative. Participants attending the full version of the training or who complete all eight units will be eligible and are encouraged to become a Dementia Friend.

On the 5th and 12th July 2016 at the Kassam Stadium in Oxford, 18 new trainers will be prepared for the further delivery of this programme. During the training, they will learn that:

- The training package is deliverable in eight units of approximately 30 minutes each. Delivery can be as one whole session or in bite size 30 minute training sessions.
- Additional materials have been added to the package to provide optional videos and vignettes to use as appropriate in your organisation. This training will also be available to access through Health Education England Thames Valley website as an online resource.
- Learning will be mapped to Tier 1 Dementia Awareness training.
- Participants will develop knowledge on presentation skills.
- Participants will receive training resources and a manual with a step-by-step guide on how to deliver the training themselves.
- On-going support to deliver the training to colleagues will be provided.
- Participants will learn how to keep a training record template and how to collect and share training data with Health Education England.

Following the training as a trainer, it is anticipated that the DAAG team members will provide additional support to them via teleconference, tutorials, and a face-to-face group meeting in the autumn 2016.

Ultimately, all of us benefit by being part of the challenge to improve the lives of people with Dementia.

Last, but we recognise by no means least, this course is offered free of charge and participants will be qualified to train colleagues, saving money on further training.

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29 Appendices

29.1 Appendix 1: Training documentation and resources reference list

Table 36: Training Courses

Course Name/Training/Info Material	Organisation	Level
Dangling Conversations	Abertay University	1
Dementia Awareness	Age UK	1
Dealing with Dementia	Age UK	1
Dealing with Dementia - Level 2	Age UK	2
Dementia Awareness in the Community	Alzheimer's Dementia Support	1
Foundation Certificate in Dementia Awareness Course	Alzheimer's Society	1
Dementia Awareness	Alzheimer's Society	1
Step inside	Alzheimer's Society	1
Level 2 training being developed	Alzheimer's Society and Royal Society for Public Health	2
Early Stage dementia awareness training for Arts Facilitators	Arts4Dementia	1
Managing risks training event	Berkshire Care Association	1
Understanding dementia for professionals	Berkshire Healthcare Foundation Trust (BHFT)	1&2
Understanding Dementia for family and friends (carers)	Berkshire Healthcare Foundation Trust (BHFT)	1
Dementia - a carer's perspective	Berkshire Healthcare Foundation Trust (BHFT)	1
Living well with Dementia	Bournemouth University	1
Managing challenging behaviour in people with dementia	Bracknell Forest Council	2
Dementia Awareness	Buckinghamshire County Council	1
Dementia Friendly Environments	Buckinghamshire County Council	1
Delirium	Buckinghamshire County Council	1
Challenge of Caregiving	Buckinghamshire County Council	1
Person Centred Planning	Buckinghamshire County Council	1
Deities and Nutrition	Buckinghamshire County Council	1
Dementia - Focal Point	Centre for Pharmacy Postgraduate Education	1
Dementia - Learning@Lunch	Centre for Pharmacy Postgraduate Education	1
Dementia Friends and Foal Point	Centre for Pharmacy Postgraduate Education	1
DESK - Dementia Care Essential Skills Knowledge for Family Carers	Carers Oxfordshire	Carers
Awareness of Dementia	City & Guilds	2
Certificate in Dementia Care	City & Guilds	2
Awareness of Dementia	City & Guilds	3

Certificate in Dementia Care	City & Guilds	3
Dementia Awareness	Coleman Training	1
SPECAL	Contented Dementia Trust	Specialist
Culture Change in Dementia Care	Dementia Care Matters	6
Leadership Matters in Dementia Care: University Recognised Course	Dementia Care Matters	Specialist
Dementia Awareness	Dementia Pathfinders	1
Dementia Awareness	Dementia Resolutions	1
An Introduction to Person Centred Care	Dementia Resolutions	2
The Alzheimer's Society Yesterday, Today and Tomorrow	Dementia Resolutions	Specialist
Yesterday, Today, Tomorrow	Dementia Resolutions	2
Safeguarding Vulnerable Adults and Dementia Awareness	Dental School - Oxford Deanery and Wessex Deanery	1
Barbara's Story - patient story	Guy's and St Thomas's NHS Foundation Trust	1
Dementia	e-Learning for Healthcare	1
Caring for people with dementia	Embrace e-learning	1
Caring for people with dementia: The fundamentals	Embrace e-learning	1
Awareness of Dementia	Embrace e-learning	2
Dementia Awareness	Forget me not Dementia Training	1
Dementia Awareness- Relatives	Forget me not Dementia Training	1
Dementia Awareness- Positive and Effective Communication	Forget me not Dementia Training	1
The Basics about Dementia	Improving Dementia Education and Awareness (IDEA)	1
Family Carer Training Programme	Home Instead	1
Dementia Care	Improving Dementia Education and Awareness (IDEA)	1
Butterfly scheme	Independent training provider	1
Bee Inspired Dementia Care Course	Jackie Pool	Specialist
Dementia Training	Memory Bubbles	1
Dementia Awareness	National College of Further Education	2
Introduction to Dementia	National College of Further Education	1
Awareness of Dementia	National College of Further Education	2
Increasing Dementia Awareness	NHS Health Check	1
Ward based dementia teaching	Older Peoples' Mental Health Liaison Team	2
Dementia Care	Open University	1
Improving Dementia Care	Open University	1
Dementia in Context for Health and Social Care	Oxford Brookes University	5-7
Dementia awareness	Oxford and Cherwell Valley College	2

Caring for People with dementia OHT study day	Oxford Health Trust	All
various training sessions	Oxford Health Trust	1
Dementia awareness training	Reading Borough Council	1
Supporting people with dementia	Reading Borough Council	2
Dementia champions	Royal Berkshire Foundation Trust (RBFT)	2
Dementia awareness (Trust induction)	Royal Berkshire Foundation Trust (RBFT)	1
The Level 2 Award in Understanding Dementia	Royal Society for Public Health	2
Come into my World	School of Nursing and Midwifery	1
Postgraduate Certificate in Dementia	School of Nursing and Midwifery	7
Open Dementia Programme	SCIE	1
Alzheimer's Disease	Sitra	Specialist
Dementia and Wellbeing	Sitra	1
Common Core Principles for Supporting People with Dementia: Developing Dementia Awareness	Skills for Health	1
Dementia	Skills Training and Re-skilling for Carers of People with Dementia	1
Dementia Care	Social Care TV	1
Dementia awareness	Sue Ryder	1
Dementia champions	Sue Ryder	1
Dementia Awareness	Tutor Care	1
Promoting Excellence in Dementia Care Study Day	University of Bedfordshire	1
Person Centred Approach to Care of the Person with Dementia	University of Bedfordshire	6
Cornerstones of Person centred Dementia Care	University of Bradford	3
Dementia Care Mapping	University of Bradford	Specialist
Developing Leadership in Person Centred Care	University of Bradford	Specialist
Dementia Studies	University of Bradford	7
Dementia Workforce Development	University of Bradford	7
Training in Dementia Care	University of Bradford	7
Getting to Know Me	University of Manchester	1
Geriatric Medicine	University of Nottingham School of Medicine	Undergraduate
Dementia	University of Northampton	6
Best Practice Care in Dementia	University of Stirling	1
BSc (Hons) Nursing (Adult and Mental Health fields)	University of West London	2
Dementia Leadership Programme	University of Worcester	7
Stand by Me	University of Worcester	1
Dementia Education Programme	University of Worcester	Specialist
Dementia Awareness	Virtual College	1
Gladys Wilson and Naomi Feil	YouTube video	1

Caring for a patient with dementia - Barbara Hodkinson	YouTube video - from e-Learning programme	1

Training Resources

Alzheimer's Society (2014) Videos and Podcasts http://alzheimers.org.uk/site/scripts/documents.php?categoryID=200451 [Accessed: 7th November 2014].

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Worcester University, *Nursing and Health Dementia Care Survival Guide*.

Table 37: Training provided in main NHS providers

Trust	Course/s	Course details
Oxfordshire Health NHS Foundation Trust	• City and Guilds Certificate in Dementia Care (Levels 2 and 3) QCF • City and Guilds Award in Awareness of Dementia level 2 • City and Guilds Award in Dementia Care level 2 • Stand By Me Training Resource - University of Worcester • Caring for People with dementia OHT study day • Various short training sessions with dement	• For residential care services staff only • For staff working in older adult/dementia services • For staff working in older adult/dementia services • For all staff • For all staff • For all staff
Oxford University Hospitals NHS Foundation Trust	• Dementia awareness online learning tool, available through SCIE • Supporting Excellence in Dementia Care in Acute and Community Hospitals and Community Health teams - University of Worcester • Stand By Me Training Resource - University of Worcester • simulation, using actors to play patients with dementia • Specialist training for medical staff • Various short training sessions with dement	• tier 1 (1 module) & tier 2 (4 modules) • For dementia leads • For all staff • For tier 2&3 • For tier 2&3 medical staff • For all staff
Higher Education provider for pre and post registration nurse training.	• Dementia is included in all nursing and other health and social care courses. • An additional optional module on Dementia is available to nursing students. • Mental health nursing has the greatest amount of dementia specific curriculum content included in a number of programme specific modules.	• Dementia mapped across all the curricula in nursing and all other pre-registration professional courses in Health and Social Care
Berkshire Healthcare Foundation Trust	• Professional carers course, combining tier1 and tier 2 learning objectives • Carers training-post diagnosis • E learning.	• 2 full days face-to-face training (2 per year for internal staff and 2 per year for staff from other organisations) • 6 sessions face-to face • 3 introductory modules tier 1 and 10 advanced

		modules tier 2
Berkshire Healthcare Foundation Trust	Specialist teams commissioned to provide training and support to host organisation • Mental health liaison team to RBH • Care home in-reach team	• See mapping document – bespoke training
Royal Berkshire Hospital	• Practice educators for each specialism e.g. networked care, planned care provide training and specialist advisors to the wards. • Involvement in corporate induction (tier 1) • Ward based teaching- sometimes in response to a specific incident) • Dementia champion training programme • dementia awareness training Toolkit • dementia awareness training • Simulation Training E-learning for healthcare E-learning SCIE Commissioning of Mental Health Liaison Team.	• Tier1 • Tier 1 or 2 bespoke • Tier 2 • Tier 1 • Tier 1 • Tier 2 • 3 introductory modules tier 1 and 10 advanced modules tier 2 • Open Dementia Programme (tier1) Specialist
Higher Education provider's pre and post registration nurse training.	UWL dementia mapping adult, mental health, learning disabilities, child and midwifery.	• Dementia mapped across the different fields curriculums. • Tier 3 dementia module being developed for delivery 2015
Central and North West London Health Foundation Trust (MK services)	University of Bedfordshire Dementia Awareness	• For all clinical staff

29.2 Appendix 2: Local Policy Documents

Bracknell Forest:
"Seamless Health" Bracknell Forest Joint Health and Wellbeing Strategy 2012 – available via http://www.bracknell-forest.gov.uk/BF-JHWS-v10-1.pdf
Bracknell Forest JSNA – available via http://jsna.bracknell-forest.gov.uk/
Bracknell Forest Joint Commissioning Strategy for Dementia 2014-2019 – available via http://www.bracknell-forest.gov.uk/Dementia-strategy-2014.pdf

Buckinghamshire:
Buckinghamshire Health and Wellbeing Strategy 2013-16 – available via http://www.aylesburyvaledc.gov.uk/GetAsset.aspx?id=fAAxADIAOAAyADAAfAB8AFQAcgB1AGUAfAB8ADAAfAA1
Buckinghamshire Joint Strategic Needs Assessment – available via http://www.buckscc.gov.uk/community/knowing-bucks/joint-strategic-needs-assessment/
Buckinghamshire JSNA Dementia – available via http://www.buckscc.gov.uk/media/1036871/Dementia.pdf

Milton Keynes:
Milton Keynes Joint Health and Wellbeing Strategy 2012-15 – available via http://www.miltonkeynesccg.nhs.uk/modules/downloads/download.php?file_name=368
Milton Keynes Joint Strategic Needs Assessment Executive Summary 2013/14 – available via http://www.milton-keynes.gov.uk/assets/attach/18992/JSNA%20Executive%20Summary%20M14066.pdf
Milton Keynes JSNA Dementia – available via http://www.milton-keynes.gov.uk/social-care-and-health/health-and-wellbeing-board/strategic-needs-assessment/jsna/jsna-dementia

Oxfordshire:
Oxfordshire's Joint Health and Wellbeing Strategy 2012-16 - available via http://mycouncil.oxfordshire.gov.uk/documents/s18182/oxfordshirejointhwbstrategy.pdf
Oxfordshire Insight: Joint Strategic Needs Assessment – available via http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment
Joint Oxfordshire Dementia Plan 2012-16: Pushing further and faster - available via http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2013/07/dementia-plan-summary.pdf

Reading:
Reading's Health and Wellbeing Strategy 2013-2016 – available via http://www.reading.gov.uk/documents%5CHealth_Social_Care%5CPublic_Health/25013/ReadingHealthandWellbeingStrategy.pdf
Reading Borough Council Joint Strategic Needs Assessment – available via http://jsna.reading.gov.uk/

Royal Borough of Windsor and Maidenhead:
Joint Health and Wellbeing Strategy for The Royal Borough of Windsor and Maidenhead October 2013 – March 2016 – available via http://www.rbwm.gov.uk/public/jhw_strategy.pdf
The Royal Borough of Windsor and Maidenhead Joint Strategic Needs Assessment – available via http://www.rbwm.gov.uk/web/jsna.htm
The Dementia Action Plan for The Royal Borough of Windsor & Maidenhead 2012-2014 – available via http://www.rbwm.gov.uk/public/social_dementia_action_plan.pdf

Slough:
Slough Health and Wellbeing Strategy 2013 to 2016 – available via
http://static.slough.gov.uk/downloads/SJWSbooklet-final-2013.pdf
Slough Joint Strategic Needs Assessment 2011-12 – available via
http://static.slough.gov.uk/downloads/JSNA-2011-Slough.pdf
Slough Borough Council: Dementia Care Strategy: A Progress Update – available via
http://www.slough.gov.uk/moderngov/documents/s31452/HSP%2021.11.13%20Dementia%20-%20report%20to%20health%20scrutiny%20Nov%202013%20Final.pdf

West Berkshire:
West Berkshire Health and Wellbeing Strategy – available at
http://info.westberks.gov.uk/CHttpHandler.ashx?id=33954&p=0
West Berkshire Joint Strategic Needs Assessment – available via
http://info.westberks.gov.uk/index.aspx?articleid=30214

Wokingham:
Wokingham Borough Council Health and wellbeing Strategy 2013-2014 – available via
http://www.wokingham.gov.uk/EasySiteWeb/GatewayLink.aspx?alId=255199
Wokingham Needs Assessment (JSNA) – available via
http://www.wokingham.gov.uk/socialcare/jsna/

29.3 Appendix 3: Stakeholder Interview Schedule

Introduction:
Thank you for agreeing to take part in the interview today – the interview shouldn't take longer than an hour to complete.

Can I just clarify before we start that you've had an opportunity to read the information sheet that I sent to you recently? The review that we are conducting is to help inform the development of dementia awareness training in the Thames Valley region, with a view to developing a more collaborative approach to the delivery of this training.

Do you have any questions that you would like to ask before we start? INTRODUCE CONSENT FORM AND TAPE RECORDER.

If you want to take a break at any time then that's absolutely fine – just let me know.

Can you tell me about the objectives/drivers for having dementia training in your organisation/service?
Prompts: Policy implications (national and local); patient need; legal requirements.

Can you tell me about the training you currently offer staff in dementia awareness?
Prompts: Length of course, content, who delivers in-house/external, level of course, forma (online, f2f), who accesses (role/level), Numbers trained and information about the facilitator expertise.

Find our course name, level etc if possible a copy of the training outline/plan.

How well do you think this training is currently meeting the needs of your organisation/service?
Prompts: For the organisation, for staff, for patients?

Do you have any examples of best practice, where this training has worked well for you?
What do you think are the current gaps in training provision for dementia awareness, if any? Are there any additional training needs which would be of benefit for your staff in the future?
Prompts: Content, level, staff reach.

Can you make any suggestions for content which you think would be most relevant for your organisation to be included in future training?

Anything that would be less relevant?

What are the implications to your organisation/service for releasing staff to attend training?
Prompts: Costs/time, hard to find cover for staff?

What training delivery methods would best suit your organisation/service?
Prompts: Half day, one or two hours over several days, online over a few months, training video. Is length of the course a factor when considering sending staff on training?

What do you think would encourage staff to attend training on dementia awareness?
Prompts: Is it compulsory, should it be? Interest by staff? What would encourage you to send/suggest training to staff?

What do you perceive to be of value when considering accessing a training course?

Prompt: Value for money, assessment of skills, quality assurance, career development, fit with staff roles, benefits to patients.

Do you currently run any schemes for dementia awareness, for example Dementia Champions, Dementia Friends etc? – how is this working?

Do you have any measures in place to monitor the impact of any training you run?

Current focus is on Tier 1 training – definition – what do you think of this?

Definition: Tier 1 (foundation level) training will familiarise staff managing patients affected by dementia with recognising and understanding dementia, interacting with those with dementia, and to be able to signpost patients and carers to appropriate support." (e-Learning for Healthcare Education)

Is there anything else you would like to add?

Thank and Close

29.4 Appendix 4: Online Staff Survey

What's it all about?
You are invited to take part survey about dementia awareness training. This research is a joint collaboration between the University of Northampton, Oxford Brookes University, University of Bedfordshire and the University of West London. This research has been commissioned by Health Education England Thames Valley. Information from this survey will be used to as part of a review and will be summarised in a report, to be given to Health Education England Thames Valley and is part of a wider project to develop a collaborative approach to the delivery of dementia awareness training in the region.

We'd like to know your opinions and experiences.

What will happen if I agree to take part?

- You can change your mind about taking part at any time, and you don't need to answer any questions you don't want to.
- All your answers will be confidential. Nothing you say will get passed onto your employers.
- Your name will not get used on anything, so no-one will know you took.

Can I say 'no, I don't want to be involved?'
Yes!
It is up to you if you want to take part.
If you say 'no' you will not have to say why you said 'no'.
No one will mind if you say 'no'.

What will happen after I've finished?
The information will be analysed and put into a report for Health Education England Thames Valley. This information may also be used to submit an article for publication or for a conference presentation and all data will remain anonymous.

For further information about the project please contact:
Alison Ward – (Researcher, University of Northampton)
01604 893559 or alison.ward@northampton.ac.uk

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1. I have understood the nature of the project, and am happy to proceed with the survey.
Yes
No

Section 1 – Dementia Training

2. How would you rate your knowledge and understanding of issues relating to dementia?
Very good
Good
Unsure
Not good
Not at all good

3. Have you accessed any training on dementia?
Yes (go to Q3a)
No (go to Q8)

3a If yes, can you tell us about the training you accessed:
Course level (if known)
Course delivered by
Length of course
Brief content of course

3b Course level (if known)
Course delivered by
Length of course
Brief content of course

3c Course level (if known)
Course delivered by
Length of course
Brief content of course

4. How did you find out about this training?
The internet
A dementia charity/organisation
A poster/flyer
Through work
Through a friend
Through family
Other (please specify)

5. Was this training:
Free to attend
Paid for by work
Paid for by you
Other (please specify)

6. Would you recommend this training to others? Please explain why/why not:
Free text

7. Was there anything that the training did not cover that you would have liked/expected it to?
Free text

8. If you have not been to any dementia training, have any of the following had an impact on your access to training? (please tick all that apply)
I'm not interested
I'm not sure where to find out about training
My work does not offer training
I don't see this as relevant to my work role
I don't see this as relevant to my personal life
I feel that I know enough about dementia already
I've read about dementia through the internet/books
None of the above
Other (please explain)
9. (All) Would you like to access (more) training on dementia awareness?
Yes
No

Not sure

10. For what reasons would you like to attend dementia awareness training? (please tick all that apply)
Develop my knowledge/awareness of dementia
Get a better understanding of how to support people with dementia
Learn best practice for working with people with dementia
Am interested in dementia issues
To recognise and understand dementia
To support interactions with people with dementia
Family/friend has dementia
Expected to attend for my work
None of the above
Other (please explain)

11. Which of the following topics, if any, would be of interest to you if attending dementia awareness training? (please tick all that apply)
Awareness and understanding of dementia
Signs and symptoms of dementia
Understanding the different types of dementia
Learning communication techniques
Understand what it is like to have dementia (carer and person with dementia perspective)
Supporting people with dementia and carers
Understanding about dementia friendly communities
Person centred care approaches/ethos
Policy and legislation on dementia
Signposting carers/people with dementia to appropriate services
None of the above
Other (please explain)

12. Thinking about your current role/employment, what issues would be most important to be included in dementia awareness training for you if accessing training.
Free text

13. Are there any barriers to you accessing training?
Cost of training
Time off work
Not interested
Not relevant to me
Other (please explain)

14. Would any of the following styles of training course be of interest to you? (please tick all that apply)
Half day workshop
Full day workshop
One hour training session
Online training course
Online forum
Training video
Other (please explain)

15. Do you think any of the following would be useful to support a dementia awareness training course? (please tick all that apply)
Hearing experiences from carers and/or people with dementia directly
Hearing experiences from carers and/or people with dementia via a video
Role play
Simulation experiences/exercises
Other (please explain)

16. What are your views on attend a training course which has a formal assessment (e.g. an essay, reflective account, presentation)?
Free text
Section 2 – About the You
It would help us if you could answer the following questions (remember, the questionnaire is anonymous). However, if you prefer not to answer a question, please leave it blank.

17. Gender
Male
Female

18. How old are you? …….. (years)

19. Do you consider yourself to have a disability?
Yes
No
I do not want to disclose this information

20. Which area of the Thames Valley Region do you live?
Aylesbury Vale
Bracknell Forest
Cherwell
Chiltern
Milton Keynes
Oxford
Reading
Slough
South Buckinghamshire
South Oxfordshire and the Vale of White Horse
West Berkshire
West Oxfordshire
Windsor and Maidenhead
Wokingham
Wycombe
Other (please specify):

21. What is your current employment status? (tick one option)
Working full time
Working part time
Studying at School/College/University
Unemployed
Other (please specify below)

22. If in employment, what is your current role?

23. If employed, in which sector do you work?
Business
Charity
Commercial
Education
Health
Local Authority
Public Sector
Religious Organisation
Restaurant/hospitality
Social Care
Other (please specify below)

24. What is your ethnicity?
Asian or Asian British
Bangladeshi
Indian
Pakistani
Any other Asian background
Black or Black British
African
Caribbean
Any other Black background
Mixed
White & Asian
White & Black African
White & Black Caribbean
Any other mixed background
White
British
Irish
Any other White background Other Ethnic Group
Chinese
Any other ethnic group
I do not wish to disclose this

Thank you for your time in completing this questionnaire.
If you have any queries or would like to know more about this project, please contact:

Alison Ward
Institute of Health and Wellbeing
University of Northampton
Park Campus
Boughton Green Road
Northampton
NN2 7AL

29.5 Appendix 5: Focus Group Schedule

Introduction

Thank you for agreeing to take part in the consultation today – the focus group shouldn't take longer than 1hr.

The aim of the focus group is to help inform the development of dementia awareness training in the Thames Valley region.

I would like to recorded today's group. The recording will be deleted following transcription and your responses will remain confidential and anonymous. Can I ask you to confirm your willingness to take part by completing the consent form?

Do you have any questions that you would like to ask before we start?

If you want to take a break at any time then that's absolutely fine – just let me know and if you would like to leave the group at anytime, please feel free to do so, although your comments to that point will be included in the findings.

Can I ask that we respect other people's views and try not to interrupt while another person is talking, I will make sure everyone has a chance to have a say. Please can I also ask that mobile phones are turned off and remind you that what we discuss today should remain confidentiality within the group.

If anyone is affected by our discussion today I have some information with some numbers for people to contact for support.

Can we start by telling me a little bit about yourselves?

We are looking at the training provision for dementia awareness, both to inform how it could be shaped in the future but also to understand what people are accessing now. Have you attended any dementia awareness training?
(Prompts: Where, level, length etc)

How have you found out about issues on dementia?
(Prompts: any information before your cared for person was diagnosed? Post diagnosis?)

Have any sources of information been particularly useful?
(Prompts: Who, why?)

Thinking about the care/services that you have used, can you tell me a little about what has worked well?
(Prompt: relate to training in care staff – GP, nurses, home care, dentists, pharmacy, opticians)

What has not worked so well?
(Prompt: relate to training in care staff – GP, nurses, home care, dentists, pharmacy, opticians)

What would you like to see included in dementia awareness training generally?
(Prompts: types of dementia, dementia friendly environments, communication, signposting to services, support mechanisms)

If you were to access training, what would you like to see included in dementia awareness training for carers?

Does this change at different stages of dementia?

How best do you think the voice of the person with dementia and carers can be represented in training?

Is this important for you?

Who do you think should be accessing dementia awareness training?

Is there anything else you would like to add?

Thank and Close

29.6 Appendix 6: Training document letter

Research study: Dementia Awareness Training
Identifying current training and understanding future needs

Dementia is a social priority which is estimated to impact on 1 in 3 people over the age 60 years by 2039.

This project seeks to identify the provision of dementia training across Thames Valley. The project will ensure that those involved or responsible in working for people with dementia receive appropriate education and training, in order to optimise dementia care. This research will be led by Health Education England Thames Valley in partnership with Higher Education Institutions from across the region.

Let me introduce the team:

- Peter Zaagman and Catherine Wheatley from Oxford Brookes University (13107203@brookes.ac.uk)
- Gwen Bonner and Debi Joyce from University of West London (Debi.Joyce@uwl.ac.uk)
- Melsina Makaza from University of Bedfordshire (Melsina.Makaza@beds.ac.uk)
- Alison Ward from University of Northampton (Alison.ward@northampton.ac.uk)

This is a three phase project running until April 2016. We are conducting the first phase, a review of current training provision in the region which will run until October 2014. This work will then inform the development of the next two phases of the project.

We would like your help with this review phase. As part of the review we are looking at the Thames Valley current best practice in training, literature and policy and we would like to undertake a scoping review of the training currently being delivered to develop people's understanding and knowledge around dementia.

I would be extremely grateful if you could let me know of any training in dementia awareness Tier 1/foundation level training which you currently deliver in house, contract in training or access online.

"Tier 1 (foundation level) training will familiarise staff managing patients affected by dementia with recognising and understanding dementia, interacting with those with dementia, and to be able to signpost patients and carers to appropriate support." *This is the definition provided by the e-Learning for Healthcare education providers formerly for Department of Health and, latterly, Health Education England.*

If possible it would be very helpful for our review if you would be able to send us some details about this training. As a guide we have developed a table to capture this data, which is attached to this letter. We kindly ask for the following details about this training:

- Name/Title of course
- Brief outline of course – key learning outcomes
- Length of course (e.g. 1 day, half day)
- Method of delivery (e.g. face-to-face or online)
- Level of course (e.g. foundation, professional)

- Level/nature of staff role the course is aimed at (e.g. for all staff, particular grade or job role)
- Approximate number of staff trained (within the last 12 months)
- Expertise of the facilitator/s (number of facilitators, type of facilitator e.g. clinical nurse, carer, trainer)
- If not delivered by yourselves, name of organisation delivering the course (e.g. in-house or name of external provider)
- Evaluation of the course (e.g. any measures to evaluate impact on practice)

Thank you for your time in providing this information, this will be an invaluable resource for understanding the range and breadth of dementia training which is available in Thames Valley, who the training is aimed at and helping to identify any gaps in provision.

The information you provide will be analysed and reported to Health Education England Thames Valley, helping to shape future dementia training provision which will support and benefit your workforce.

If you have any other information or suggestions of people you think it would be helpful for me to contact, I would be extremely grateful for your input.

Please can you return the completed information to me by the 29th August 2014 so that we can complete this phase by October 2014.

If you have any queries or would like further information about the project please contact myself or one of the team via our email addresses or the contact details below.

Thank you again for you time and support for this project.

Yours sincerely

29.7 Appendix 7: Roles and Responsibilities of Partner Universities and HEE TV

University of Bedfordshire Oxford Brookes University	**University of West London**	**University of Northampton**	**HEE TV**
Support and attend steering group meetings	Support and attend steering group meetings	Support and attend steering group meetings	Support and attend steering group meetings
Support and attend teleconference meetings in between steering group meeting	Support and attend teleconference meetings in between steering group meeting	Support and attend teleconference meetings in between steering group meeting	Support the DAAG with identifying pilot sites
Project manage Phase 2 – Training Delivery Support with evaluation to training during delivery phase.	Project manage Phase 3 Evaluation. Ensure ethics approval for Phase 3	Support with Phase 2 Training delivery	Supply DAAG with details of pilot sites and estimated number of staff that need training
In consultation with Project Team, develop Tier 1 training packages and resources that build on Phase 1	Support the development of Tier 1 training packages and resources that build on Phase 1	Support the development of Tier 1 training packages and resources that build on Phase 1	Provide feedback about the proposed Tier 1 training packages.
Provide proposed Training Delivery Schedule with details of proposed dates for Phase 2	Provide details of proposed dates for Phase 2	Provide details of proposed dates for Phase 2	Provide feedback about the proposed Tier 1 training Delivery Schedule
Project manage and deliver Phase 2 training including providing delegate information to facilitate the evaluation of the packages.	Deliver Phase 2 training and support in the collection of information for the evaluation.	Deliver Phase 2 training and support in the collection of information for the evaluation.	Provide feedback and guidance regarding the progress of the report
Provide progress reports to the Commissioners, Project Team and issue reminders.	Provide progress reports to the Phase 2 lead	Provide progress reports to the Phase 2 lead	Review the final report and provide input and feedback
Support the evaluation of Tier 1 training being delivered at pilot sites. Support the final analysis and report writing.	Coordinate Phase 3 evaluation, parallel to Phase 2. Collate and analyse data for discussion by the DAAG.	Support the evaluation of Tier 1 training being delivered at pilot sites. Support the final analysis and report writing.	Support the dissemination of findings
Contribute to the final report	Synthesise the findings into a final draft report	Contribute to final report	Provide feedback and comment the final report
Support the dissemination of findings	Support the dissemination of findings	Support the dissemination of findings	

29.8 Appendix 8: Timeframes Phases 2 and 3

The following is a proposed time frame for delivery of Phase 2 training and indicative dates for Phase 3 completion of this project.

	Jan 2015	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2016	Feb	Mar	April	May
Project Committee Meetings	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦
Phase 2 & 3 proposal development	🟦	🟦	🟦	🟦													
Proposal agreed				20/04/15													
Identification of pilot sites	🟦	🟦															
Allocation of Pilot Sites		🟦	🟦														
Development of Tier 1 Training Packages	🟦	🟦	🟦	🟦	🟦												
Pilot Training Packages			🟦														
Development of Training delivery schedule			🟦	🟦													
Development of Train the Trainers Programme				🟦	🟦	🟦											
Delivery of Training					🟦	🟦	🟦	🟥	🟦	🟦	🟦	🟥					
Data collection					🟦	🟦	🟦	🟥	🟦	🟦	🟦	🟥					
Data analysis									🟦	🟦	🟦	🟥	🟦	▨			
Collaborative enquiry workshop (tbc)													18/01/16				
Draft Final report (tbc)														15/02/16			
Final report (tbc)															14/03/16	🟧	🟧

29.9 Appendix 9: Standard Package

Standard Dementia Training Package – Session Plans (Version 1)
Dementia Academic Action Group
Session Plan

Title: Tier 1 Dementia Training ~ Standard Package

Organisation: **Number of participants in the group:**

Date: **Duration of Session: 2 hours**

Venue:

Key words: Tier 1 Training, Dementia Awareness, Dementia Strategy, Communication, Living Well with Dementia.

Aim:
This session has been designed to provide face-to-face training to clinical and non-clinical staff working in a variety of health and social care settings with a basic awareness of what dementia is and how it affects the person with dementia along with their family, relatives, carers, friends and significant others.

The session provides a definition of what dementia is, some of the types, how it manifests itself and the impact that the increased numbers of people with dementia have on the health and social care systems in the Thames Valley Region. The content has been shaped by the Skills for Health Standards (Health Education England); The National Institute for Health Research (NIHR) Collaboration for leadership in Applied Health Research and Care (CLARC) or PenCLAHRC; Higher Education Dementia Network (HEDN) and findings from Phase 1 of the Health Education England Thames Valley (HEE TV) Dementia Research Project.

Objectives:
By the end of the session, the participants should be able to:

- Explain what dementia is, how it affects people with dementia and their family, relatives, carers and significant others.
- Describe the impact of dementia and the support that people with dementia and their carers require.
- Name some useful strategies or hints & tips that can be used to support the person with dementia at whatever stage.

Time	**Content**	**Facilitator Activity** **“What the facilitator will be doing”**	**Participant Activity** **“What the learners will be doing”**	**Teaching Aids**
9:15 am	**Welcome,** Setting of ground rules including disclosure of sensitive information and confidentiality.	Facilitating discussion	Listening, participating	Flip chart paper, pens, white board, handouts
9:20 am	**Activity 1 (3 minutes)** Participants to complete the **“Forget Me Not” Task**: ***“When I can’t tell you what I want, this is what’s important to me……”***	To start ask everyone to write down the most important thing that they would want to happen if they were to end up being cared for by others (3 minutes). Ask participants to put the answer away for the moment. Facilitator will refer to it at a later part of the session.	Individual activity: Participant to complete the **“Forget Me Not”** Task using a pre-printed sheet of paper.	Pre-printed sheets of paper with “Forget Me Not” Task.
9:25 am	**Activity 1B (5 minutes)** Participants to work in pairs/trios and to discuss the following statement: ***“Discuss your professional and/or personal experience of dementia”*** **5 minute feedback** **(10 minutes in total)**	Ask the audience to discuss in pairs/trios what their experience of dementia has been **(5 minutes)** After 5 minutes, ask for a few examples to share with the group. If little is forthcoming from the participants, you can use examples from your own experience.	**Group activity:** Pairs or small group discussion about **personal and/or professional experiences of dementia**. **5 minutes**	Power point
9: 35am	**Power Point Presentation: “What is Dementia?”** **(10 minutes)**	Present content from Slide 7 - 9	Listening and participating mentally	Power point
9:45 am	**Activity 2:** **Video presentation ~ “Living with Dementia”** **(11 minute video)** **Audience discussion:** **(4 minutes)** **(15 minutes in total)**	**Facilitator explains:** “This is a video that lasts for 11 minutes and it is from SCIE TV (Social Care Institute for Excellence) Television. It presents the experience of dementia directly from the people who are experiencing it. After 11 minutes**, involve audience in a discussion about what they just viewed.** Any lessons learned?	**Watch SCIE TV Video entitled: “Living with Dementia”** After watching video, engage in audience discussion about the content of the video. **Discuss lessons learned.**	**Hyper Link is embedded in Power Point Presentation Slide.** To open, place cursor on the words “Video Clip”, right click on the mouse and a drop down menu will appear, left click on the mouse on the words, “open hyperlink”. This will take you to video on the website.
10:00 am	**Power point Presentation: “The National Dementia Strategy ~ Diagnosis”**	Presentation from Slide 11 – 17 **(10 minutes)**	Listening & participating mentally	Power point
10:10 am	**Activity 3: Video Presentation ~ The experience of Dementia”**	**The Facilitator explains:** This video presentation shows the experience of a person who dementia and it charts their	**Watch “Barbara’s Story”** After watching video, participants to	**Hyper Link is embedded in Power Point Presentation Slide**.

	Barbara's Story **(34 minutes)** **(40 minutes in total)**	journey through a variety of health and social care situations. The facilitator needs to encourage each member in the audience to see if their role/department/profession is represented in the video and for them to consider how the dementia affects the person, family as well as the professionals represented in the video.	engage in audience discussion about the content of the video. • Discuss lessons learned? • Any areas for personal and professional development identified?	To open, place cursor on the words "Video Clip", right click on the mouse and a drop down menu will appear, left click on the mouse on the words, "open hyperlink". This will take you to video on the website.
10:50 am	**Power Point Presentation:** **"Living Well with Dementia"**	Presentation from Slides 19 – 24 **10 minutes**	Listening and participating	Power Point
11: 00 am	**Activity 4 ~ "Now What?"** **(10 minutes)**	**Facilitator to state:** We are now at the end of the presentation. Ask them to think back to the **'Forget Me Not'** exercise and ask for a few to volunteer what they wrote down on their statement. Ask people to think about actions they will take following the workshop – **one thing you will <u>stop</u> doing** and **one thing you <u>will do</u> from now on**. If they are not already Dementia Friends, encourage them to become a Dementia Friend as a way of raising wider awareness.	Participants to retrieve the "Forget me Not" statement that they wrote at the start of the session. Few to volunteer some of the statements that they wrote. How do they feel about these statements, in view of the training that they have just received?	Power point, Access to website
11:10 am	**Summary** **Question Time** **Review of Objectives from the start of the session** **(5 minutes)**	Verbal feedback to the group about how it felt for facilitator. Giving out handouts/ information pack. Sign post to electronic resources.	Verbal feedback Completion of evaluation forms.	**Evaluation Forms** **Information Packs** **Online Resources** **Recommended reading Dementia Apps on iTunes & Android.**
11:15 am	**End of session.**			

29.10 Appendix 10: Extended Package

Dementia Academic Action Group
Session Plan

Title: Tier 1 Dementia Training ~ Extended Package

Organisation: **Number of participants in the group:**

Date: **Duration of Session: 1 hour 15 minutes**

Venue:

Key words: Extended Tier 1 Training, 3 D's of Dementia, Consent, Capacity, Communication.

Aim:
This session has been designed to provide face-to-face training to clinical and non-clinical staff working in a variety of health and social care settings who already have a basic awareness of what dementia is and would like to develop further understanding.

The session provides a refresher of what dementia is, the diagnosis process and how delirium, depression and dementia can manifest themselves during that process. Participants will be helped to consider the emotional impact of the diagnosis of dementia and will be encouraged to think about the legal and ethical issues surrounding mental capacity and consent in the person with dementia.

The content for this extended package has been shaped by the Skills for Health Standards (Health Education England); The National Institute for Health Research (NIHR) Collaboration for leadership in Applied Health Research and Care (CLARC) or PenCLAHRC; Higher Education Dementia Network (HEDN) and findings from Phase 1 of the Health Education England Thames Valley (HEE TV) Dementia Research Project.

Objectives:
By the end of the session, the participants should be able to:

- Explain what dementia is, how it is diagnosed and how the process can be affected by the presence of delirium and depression.

- Describe the emotional impact of dementia diagnosis and the support that people with dementia & their carers may require.
- State some of the legal and ethical issues in dementia and identify the strategies that can be used to support the person with dementia at whatever stage.

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Time	Content	Facilitator Activity **“What the facilitator will be doing”**	Participant Activity **“What the learners will be doing”**	Teaching Aids
11:30 am	**Welcome,** Setting of ground rules including disclosure of sensitive information and confidentiality. (5 minutes)	Facilitating discussion	Listening, participating	Flip chart paper, pens, white board, handouts & other supporting materials will be available electronically on HEE TV Website. Information pack will be made available at the end of the session.
11:35 am	**Activity 1 (5 minutes)** Participants to complete the **“Reflections”** : ***“Who do you know that has dementia? How does it affect them? How do you now interact with people who have dementia? ”***	Split the audience into small groups of up to 6 people. **Nominate:** Time Keeper, Scribe & Spokesperson. Allow time for the groups to give some feedback from their discussions. Set the task for the Spokesperson to feedback in 60 seconds or less. This usually helps to keep to time. **(10 minute activity)**	**Group activity:** Participant to work in small groups and to reflect on & discuss their previous dementia training. To answer the following questions: ***“Who do you know that has dementia? How does it affect them? How do you now interact with people who have dementia?”***	Blank paper for participants to write on.
11:45 am	**Power Point Presentation: “What is Dementia?”** **(5 minutes)**	Present content from Slide 7 - 9	Listening and participating mentally	Power point
11:50 am	**Activity 2:** **Video presentation ~ “Getting to know the person with Dementia – Impact of Diagnosis”** **(17:34 minute video)** **Audience discussion: (3 minutes)**	**Facilitator explains:** “This is a video that lasts for 17:34 minutes and it is from SCIE TV (Social Care Institute for Excellence) Television. It presents the impact of diagnosis of dementia directly from the people who are experiencing it. After 17 minutes**, involve audience in a discussion about what they just viewed.** ssons learned?	**Watch SCIE TV Video entitled: “Getting to know the person with Dementia – Impact of Diagnosis”** After watching video, engage in audience discussion about the content of the video. **ss lessons learned.**	**Hyper Link is embedded in Power Point Presentation Slide.** To open, place cursor on the words “Video Clip”, right click on the mouse and a drop down menu will appear, left click on the mouse on the words, “open hyperlink”. This will take you to video on the website.

	(20 minutes in total)			
12:10 pm am	**Power point Presentation:** **“The Emotional Aspects of Dementia for Carers”** **5 minutes**	Presentation from Slide 10 – 12 Slide 12: Facilitator to state: Instead of communication going via the person with dementia there is a continuous three way communication patterns established, called the triangle of care. This is outlined in a joint publication of the Carers Trust and the RCN foundation in 2013.	Listening & participating mentally	Power point
12:15 pm	**Activity 3: Audience Participation ~ “How do you communicate with the person with dementia?”** **(3 minutes in total)**	**The Facilitator explains:** The facilitator needs to encourage each member in the audience to think about how they communicate with the person with dementia	Discuss experiences learned? Any areas for personal and professional development identified?	.
12:20 pm	**Activity 4 ~ “Effective Communication ~ Use VERA?”** **(10 minutes)**	**Facilitator to:** 1. Get the audience into 4 groups 2. Give each group 1 card 3. Show sample response after each group has fed back. 4. Ask them to spend 5 minutes discussing the topic written on their card. Invite the Spokesperson to give feedback in 60 seconds or less.	**Scenario Based Activity:** Participants to get into 4 groups. **Group V: Validation** How would you use Validation to help Mary? What might you say or do in response to her concerns? **Group E: Emotion** How would you acknowledge Mary’s emotions? What might you say or do in response to her emotions? **Group R: Reassurance** Having observed that Mary is looking tense, how would you re-assure her? What might you say or do as you re-assure her? **Group A: Activities** How would you use activities to help Mary? What might you say or do in order to encourage Mary to engage in activities?	**Power point,** **Resources:** 4 laminated cards with the letters VERA printed on each card. For example, one card will have V on it and on the reverse side it will have the scenario printed on it and then a question for discussion:

12:30 pm	**Power point presentation:** **“The main behavioural symptoms in Dementia”** **10 minutes**	Present Slides 20 - 25	Listening & participating mentally	**Power point**
12:40 pm	**Summary** **Question Time** **Review of Objectives from the start of the session** **(5 minutes)**	Verbal feedback to the group about how it felt for facilitator. Giving out handouts/ information pack. Sign post to electronic resources.	Verbal feedback Completion of evaluation forms.	**Evaluation Forms** **Information Packs** **Online Resources** **Recommended reading** **Dementia Apps on iTunes & Android.**
12:45 pm	**End of session.**			

29.11 Appendix 11: list of professional roles and titles

Medical and Dental	
Clinical director	1
Clinical Governance Facilitator/ Locum GP	1
Consultant Psychiatrist	1
Consultant Geriatrician	1
Dental Officer	4
Dental Therapist	2
Dentist	6
General Practitioner	37
GP - Registrar	4
Medical Student	2
Orthoptist	1
Orthopaedic Practitioner	1
psychiatric liaison clinician	1
Psychotherapist	1
RMO	1
Senior Dental Officer	2
Specialist Lead Clinician	1
Specialist Lead Clinician -Dental	1
STR in Special Care Dentistry	1
	69
Registered Nurses	
Advanced Nurse Practitioner	1
Charge Nurse	1
Clinical Practice Educator	1
Community Matron	1
Community MH Nurse	2
Community Nurse	9
Community Nurse (continence nurse)	1
Community Nurse (DN)	24
Community Practice Nurse	1
Continence Nurse	2

Dementia friendly community manager	1
Diabetes specialist nurse	1
Discharge Liaison Nurse	2
District Nurse	1
Health Visitor	7
IPC Nurse	1
IBD ANP (Nurse)	1
Lead Discharge Liaison Nurse	1
Lead Nurse in Personal Safety	1
Lead nurse for Specialist Services	1
Lead Nurse	1
Lecturer in Adult Nursing	1
Macmillan Nurse Hysteroscopist	1
Matron	1
Mental Health Nurse	2
MH Community Nurse	2
Modern Matron	1
Night Sister	3
Nurse	19
Nurse (HV)	1
Nurse Colposcopist	1
Nurse Consultant	1
Nurse Manager	1
Nurse Practitioner	1
Out Patient Department Nurse	1
Palliative Care CNS	1
Practice Nurse	36
Registered Nurse	1
Respiratory Nurse	1
RGN	10
RGN in charge of Dementia wing	1
RGN Care Home Support Team, OAMHT	1
RGN Ward Sister	1

RMN	1
Senior Nurse	4
Sister	1
Sister (ENT) in Out Patients Department	1
Sister Ophthalmology	1
Sister/ward manager	1
Snr Research Nurse	1
Specialist Nurse practitioner	1
Specialist Nurse practitioner (falls)	1
Specialist Nurse - VTE	1
Staff nurse	24
Staff Nurse Dermatology	2
Staff nurse ENT OPTS	1
Staff Nurse hospice	1
Staff Nurse OPD	1
Staff Nurse Out Patient	1
Trainer/Facilitator RGN	1
Tissue Viability Nurse	1
Ward Sister	2
	196

Scientific, Therapeutic and Technical Staff	
Biomedical Scientist	2
Cellular Pathology	1
Clinical Psychologist	1
Colposcopist	1
Community Dietetics	1
Community Dietician	1
Community MH Practitioner SW	3
Deputy Chief Pharmacist	1
Dietitian	4
Mental Health Practitioner	2
MPET Pre-Registration	1

Night practitioner	1
Occupational Therapist	14
Occupational Therapist Oxford County Council	4
Optometrist	2
OT Team Leader	1
Pharmacist	5
Physiotherapist	10
Physiotherapy Instructor	2
Radiographer	10
Researcher	1
Senior mental health practitioner	1
Senior Radiographer Imaging	2
Senior OT	1
Senior Physiotherapist	1
Senior Social Worker	1
Speech & Language Therapist	6
Social worker	3
SSN Imaging	1
Superintendent Radiographer	3
	87
Registered Ambulance Staff	
Emergency care practitioner (paramedic)	1
Mobile Responder	1
Paramedic	15
Paramedic/Education Manager (Older Adult, Frailty and Dementia)	1
Specialist Paramedic Practitioner	1
	19

Support to Clinical Staff	
Activities coordinator	9
Admin/Receptionist	2
Assessor (NHS)	2
Assistant Practitioner	2

Assistant Psychologist	2
Behaviour Specialist	1
Care assistant	74
Clin. Skills & Simulation Technician	1
Community Care Assistant	1
Community Dental Nurse	1
community engagement	1
Community HIV Support Worker & Trainer	1
Complaints & PALS manager	1
Complaints & PALS Officer	1
Complaints manager	1
CPD Tutor	1
Dementia Advisor	1
Dental nurse	2
Dental Staffing	2
Diabetic Assistant	1
Diabetic Eye Screening	2
Dietetic Assistant	1
Dispenser	4
Falls coordinator	1
Grader BDES	3
Health Care Assistant/Admin	1
Health Care Assistant	75
Health Care Assistant - Theatre	1
Healthcare Support Worker	1
ICS Senior Support Worker	1
ICS Support Worker	6
Imaging Assistant	2
Independent Living Officer	4
Library & E-Learning Services Manager	1
Library Assistant	2
Lifestyle Co-ordinator	1
Litigation Administrator	2

MacMillan Care Assistant	1
Maternity Care Assistant	1
Mental health nursing student	1
Midwifery student	48
Moving and Handling Advisor	1
Nursing Assistant	8
Occupational Therapy Assistant Oxford County Council	1
ODP students	85
Ophthalmic Technician	3
OT student	96
Paediatric Dietetic Assistant	1
Patient Tracker & HCA in A&E	1
Pharmacy Dispenser	1
Pharmacy Technician	2
Reablement Assistant	10
Reception Manager	4
Receptionist	105
Recovery Lead	2
Rehab Assistant	2
Rehab Support Worker	1
Rehabilitation Assistant	1
Research Assistant	1
Respiratory Physio Assistant	1
Scanner	1
School Health Assistant	1
Senior Care Assistant	5
Senior Healthcare Assistant	1
Senior Research Administrator	1
Senior Support Worker	
Senior Reablement Assistant	1
Speech and Language Therapy Assistant	2
Senior Support Worker	4
Senior ward house keeper	1

Student Nurse	20
Student Midwife	40
Support Worker	64
Support Time and Recovery Worker	3
Trainee Assistant practitioner	1
Trainee Specialist Paramedic	5
Vocational Development Lead	1
Ward Clerk	8
Ward administrator	1
	752
Infrastructure Support	
Administrator	32
Admin assistant	10
Admin Co-ordinator	1
Assistant Domestic Manager	1
Assistant Manager	1
Assistant Practice Manager	2
Associate Dean QI	1
Bereavement Service Manager	1
Booking co-ordinator	1
Business Support	1
Care Coordinator	1
Care Home Manager	2
Care Manager	2
Care Supervisor	1
Catering assistant	1
Catering Supervisor	1
CDM Secretary	1
Chef/cook	2
Clinical Governance & Risk Administrator	2
Clinical Governance & Risk Facilitator	1
Communications Officer	1
Community Nurse manager	1

Contracts officer	1
Data & Quality officer	1
Day Hospital Coordinator	1
Dementia friendly community manager	1
Dementia project lead	1
Deputy Reception Manager	1
Deputy Manager	1
Deputy Practice Manager	1
Deputy Lead Receptionist	1
Director of Corporate Affairs	1
Domestic	7
Domestic assistant	20
Domestic Supervisor	1
Duty Officer	2
Executive PA	1
Facilities support Manager	1
Finance administrator	1
General Manager	1
Fundraising Officer	2
Group Practice manager	1
Head of Communications	1
Head of Risk & Clin Gov	1
Health & Safety Advisor	1
Health care manager	1
Housekeeper	19
Housekeeping team leader	1
Hostess	1
Information Governance Officer	2
IT Manager	2
Joint commissioning manager	1
kitchen Assistant	1
laundry assistant	1
Lead Receptionist	1

LAC Teams manager	1
Manager	6
Medical Records Clerk	9
Medical records summariser	1
medical secretary	5
Memory Clinic/Team Secretary	1
Office manager	2
Operations Manager	1
Outreach & E-Learning Librarian	1
PA	1
Patient Administrator	1
Patient Experience Admin	1
Patient Pathway Admin	1
Patient Pathway Coordinator	2
Patient Pathway Scheduler	1
patient services manager	1
Performance Leader, Wokingham CMHT	1
Personal Safety Trainer/Mental Health Nurse	1
Physiotherapy Administration Team Lead	1
Physiotherapy Administration Team Lead	1
Porter	1
Porter/Handyman	4
Practice Manager	18
Prescription clerk	2
Principal Recruitment Officer	1
Programme Facilitator	1
Project Manager, Older People	1
Quality and Contacts officer / Dementia Advisor	1
Quality & Contracts Officer	1
Registered Manager Intermediate Care	2
Registered Care Manager	1
Registered Manager	2
Risk and Systems Manager	1

SCUIN Administrator	1
Secretary	13
Senior Administration Assistant	1
Senior Administrator	1
Senior Commissioning Manager	1
Senior Library Assistant	1
Senior manager	1
Senior Receptionist	1
Senior Receptionist & ECG Technician	1
Service manager	3
service team manager	1
Team Leader	3
Team Secretary	3
Theatre Manager	1
Voluntary Services coordinator	1
Volunteer Manager	1
	256

Others	
Carer	6
Not recorded/unknown	67
Parish Councillor	1
PPG Rep	1
PPG & Carers Rep	1
Retired Nurse	1
Volunteer	16
	93

29.12 Appendix 12: Dementia Awareness Tier 1 Training Evaluation Form

Dementia Awareness Tier 1 Training Evaluation Form

This questionnaire aims to explore if attending dementia awareness training has increased your knowledge of dementia and explores your intentions regarding changes to your working. Please remember there are no right or wrong answers. All data collected in this survey will be held anonymously and securely. The information you provide will not be able to identify you individually. By completing this questionnaire you are consenting to your data being included in the evaluation.

***Please can you complete this questionnaire to help* inform the future dementia awareness training to ensure that it is meeting the needs of staff in the region**. This questionnaire should take approximately five minutes to complete. **Thank you for your time.**

What is your job title?	**In your job role do you have regular contact with people with dementia**			
	Yes		***No***	
Do you have face-to-face contact with patients /clients	***Yes***		***No***	
Please circle if your role is clinical or non-Clinical?	***Clinical***		***Non-clinical***	
Please circle what type of organisation you work	***Primary care***	***Hospital***	***Community***	***Care home***
Venue of training				
Have you had any previous dementia training?	***Yes***		***No***	

Q1 Please look at the statements below to compare how much knowledge you feel you have about dementia before and at the end of the training (after). Please answer all statements

Before the training							**After** the training					
None	Poor	Fair	Good	Very Good	Excellent	I would rate my level of knowledge in:	None	Poor	Fair	Good	Very Good	Excellent
1	2	3	4	5	6	**Recognising the signs and symptoms of dementia**	1	2	3	4	5	6
1	2	3	4	5	6	**Understanding the impact of dementia on individuals , families and society**	1	2	3	4	5	6
1	2	3	4	5	6	**Understanding person centred approaches to supporting people with dementia**	1	2	3	4	5	6
1	2	3	4	5	6	**Communicating compassionately with people with dementia**	1	2	3	4	5	6
1	2	3	4	5	6	**Understanding risk factors for dementia**	1	2	3	4	5	6
1	2	3	4	5	6	**Signposting to sources of support**	1	2	3	4	5	6

Q2 Please tick your level of agreement with the 3 statements below. As a result of the training:

	Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
I feel my attitude to people with dementia is more positive.					
I feel this training has improved my skills in working with people with dementia					
I feel more confident in interacting people with dementia.					

(Adapted from O'Connor, 2010)

Q3 What are three things most important things you learnt during today's dementia awareness session?

1)

2)

3)

(Standard Training Only) Please turn to the back page once completed.

Extended Training Only

Q4. When did you do your Standard Training? (Please circle)

Today Within the last month Over a month ago

Q5 Please answer this question only applies if you are attending the extended session. If you are attending the standard session go to question 3.

Please look at the statements below to compare how much knowledge you feel you have about dementia before and at the end of the training (after). Please answer all statements

Before the training							**After** the training					
None	Poor	Fair	Good	Very Good	Excelle	I would rate my level of knowledge in:	None	Poor	Fair	Good	Very Good	Excelle
1	2	3	4	5	6	**Awareness of delirium and depression**	1	2	3	4	5	6
1	2	3	4	5	6	**The emotional impact of dementia on the individual and their carer**	1	2	3	4	5	6
1	2	3	4	5	6	**How behaviour can be a means of communication in people with dementia**	1	2	3	4	5	6
1	2	3	4	5	6	**Tips and techniques for communicating effectively with people with dementia**	1	2	3	4	5	6
1	2	3	4	5	6	**Mental capacity and decision making in people with dementia**	1	2	3	4	5	6

Thank you for completing the form- please hand in at the end of the session

We would like the opportunity to discuss the training programme with you, and to explore factors which help or hinder people applying what they learnt during the training into practice. We would like to send you a follow up questionnaire by email, (in about 6 weeks), which should take no longer than 10 minutes to complete and/or to take part in a 15 minute telephone interview. If you are willing to be contacted please give your e mail or telephone number below. Your personal information will be held securely and only used for the purposes of this project.

Name Telephone

E-Mail

Address: (for paper copies only)

I am happy to be contacted to take part in the telephone interview

Yes No

If yes, please circle what time of day is convenient:

Morning Afternoon

Evening

I am happy for you to email me a 6 week follow up online questionnaire

Yes No

I am happy for you to send me a 6 week follow up paper questionnaire

Yes No

Thank you for your time

29.13 Appendix 13: Dementia Awareness Post-training Follow-up

Dementia Awareness Post-training Follow-up- All participants

This questionnaire aims to explore if attending dementia awareness training has increased your knowledge of dementia and explores your intentions regarding changes to your working practices as a result of the training. Please remember there are no right or wrong answers. All data collected in this survey will be held anonymously and securely. The information you provide will not be able to identify you individually. By completing this questionnaire you are consenting to your responses being included in the evaluation. The information you provide will be used to inform the future development of dementia awareness training to ensure that it is meeting the needs of staff in the region.

This questionnaire should take approximately ten minutes to complete. Thank you for your time.

About you

What is your job title?	**In your job role do you have regular contact with people with dementia**			
	Yes		***No***	
Do you have face-to-face contact with patients/clients	***Yes***		***No***	
Please circle if your role is clinical or non-Clinical?	***Clinical***		***Non-clinical***	
Please circle what type of organisation you work	***Primary care***	***Hospital***	***Community***	***Care home***
Venue of training				
Have you undertaken any other dementia training	***Yes***		***No***	

You have recently attended a Dementia Awareness Training Session. The training consisted of a 'standard session' and / or an 'extended session'

Firstly, please indicate which training you attended

☐ Standard Session only, ***which covered information on understanding, recognising, and interacting with people with dementia.***

☐ Standard **and** extended session (attended on the same day) ***which covered the 3 D's, Vera framework, decision making and the Mental Capacity Act.***

☐ Standard **and** extended session (attended within 1 month of each other).

☐ Standard **and** extended session (attended over 1 month apart).

Knowledge and understanding

1. Please tick your level of agreement with all of the 6 statements below. As a result of the training:

	Stayed the same	**Improved a little**	**Improved moderately**	**Improved considerably**
I feel my ability to recognise the **signs and symptoms** of dementia has improved.				
I feel my level of knowledge of the **impact of dementia on individuals, carers** has improved.				
I feel my ability to understand **why a person with dementia may exhibit signs of distress**				
I feel my ability to **communicate compassionately** with people with dementia has improved.				
I feel my understanding of **person centred approaches** to supporting people with dementia has improved.				
I feel my understanding of **signposting** people with dementia and their cares to sources of support has improved.				

2. Transferring training to practice

Have you been able to apply what you learnt on the training to your job role?

☐ Yes ☐No

3. a. If 'yes', please tell us what you think has changed (select all that apply)

☐ Confidence

☐ Communication Skills

☐ Empathy / Understanding

☐ Adapted Environment

☐ Signposting

☐ Other (please specify): ____

3.b. If 'no', please tell us the reasons why you have not been able to apply the knowledge gained from the training to your job role (select all that apply)

☐ I don't work regularly with people with dementia

☐ I'm too busy to apply what I've learnt

☐ I'm not confident to apply the knowledge

☐ I need more managerial support

☐ I need more training (please specify) ____

☐ Other (please specify): ____

4. Please tick your level of agreement with the 3 statements below. <u>As a result of the training</u>:

	Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
I feel my attitude to people with dementia is more positive.					
I feel this training has improved my skills in working with people with dementia					
I feel more confident in interacting people with dementia.					

<u>Training content</u>

5. Is there anything you would add to the training?

____

____

____

____

6. Please tell us if there is there is anything you would remove from the training content?

____

____

____

____

7. If you attended the extended training please describe what value, if any, you feel you have gained from attending this in addition to the standard session.

____

____

____

____

Thank you for participating.

29.14 Appendix 14: Dementia Awareness Tier 1 Training Evaluation Telephone Interview Schedule

Dementia Awareness Tier 1 Training Evaluation Telephone Interview Schedule

PLEASE READ THE FOLLOWING TO THE PARTICIPANT

Introduction:
The evaluation we are conducting is to help inform the development of dementia awareness training in the Thames Valley region, with a view to developing a more collaborative approach to the delivery of this training.
You have been invited to, and have agreed to a telephone interview. This interview should not take longer than 15 minutes to complete.

Your Rights:
You have the right to stop being part of this research without explanation. Any data you supply will be withdrawn/destroyed.
You have the right to skip or reject to answer or reply to any question that is asked of you.
You have the right to have your questions about the processes answered. If you have any questions after reading this information sheet, you can ask me at any point during this study.
There are no known benefits or risks for you in this study.

Confidentiality
The data collected does not contain any personal information about you. No one will link the data you provided to the identifying information you supplied. The interviews will be recorded so a transcription of the interview can be carried out. Your name on the transcript will be changed so that complete anonymity can be ensured.

For Further Information
If you would like to know more information, or would like to withdraw (including after the interview has taken place), please don't hesitate to contact ___
If you would like to find out about the final results of this study, please email the above email address.

Consent:

1. *Can I just clarify before we start that you've had an opportunity to read the information sheet that I sent to you recently?*
2. *Do you give consent for this interview to begin, including audio recording?*

   Yes / No
3. *Do you have any questions that you would like to ask before we start?*

Firstly can I ask a couple of questions about you?

What is your job title?				
In your job role do you have regular contact with people with dementia	***yes***		***No***	
Do you have face-to-face contact with patients /clients	***yes***		***No***	
Please circle if your role is clinical or non-Clinical?	***Clinical***		***Non-clinical***	
Please circle what type of organisation you work	***Primary care***	***Hospital***	***Community***	***Care home***
Venue of training				

1. **Did only attend the standard training only (2 hours) , or did you also attend the extended training too (1.5 hrs.) ?**

   Prompt – At what point was the extended training after the standard training?

2. **Can you tell us what your thoughts are on the Dementia Awareness Training you received?**

   Prompt - Length of session/content

3. **Is there anything you feel should have been done differently?**

4. **Have you been able to apply what you have learnt to your job role?**

   Prompt – if yes please tell me about what within the organisation has helped

   - If no please tell me about any barriers that you feel have prevented this, or make it difficult

5. **We are also looking at things that help or hinder people applying what they have learnt during training and putting it into practice. What would you say helps or hinders you?**

   Prompt – individual level (buddy system, personal development plans) organisational/systems level (e.g. appraisal system, training as part of induction)

6. **Do you feel attending the training has made any difference to your feelings of confidence when around people with dementia, and why / why not?**

7. **Do you have any comments regarding additional training that would feel you still need to help you support people with dementia and their carers better?**

   Prompts **-** Content, level, type of training e.g. mentorship/ assessed courses

8. **Is there anything else you would like to add?**

Thank participant and Close

29.15 Appendix 15: Independent t-test results on differences in knowledge gained between clinical and non-clinical staff before and after training

	Clinical Staff		Non-clinical Staff				
Items	Mean	SD	Mean	SD	t	df	Sig.
Recognising the signs and symptoms of dementia – before	3.55	.938	3.16	1.05	6.151	993	.000**
Recognising the signs and symptoms of dementia – after	4.62	.72	4.52	.81	2.155	980	.031*
Understanding the impact of dementia on individuals, families and society – before	3.82	.98	3.45	1.10	5.611	991	.000**
Understanding the impact of dementia on individuals, families and society – after	4.87	.73	4.81	.74	1.166	984	.244
Understanding person centred approaches to supporting people with dementia – before	3.57	1.05	3.05	1.17	7.266	988	.000**
Understanding person centred approaches to supporting people with dementia – after	4.82	.77	4.61	.82	4.110	977	.000**
Communicating compassionately with people with dementia – before	3.93	1.03	3.55	1.14	5.480	993	.000**
Communicating compassionately with people with dementia – after	4.91	.76	4.78	.77	2.720	985	.007*
Understanding risk factors for dementia – before	3.47	1.15	3.12	1.16	4.723	993	.000**
Understanding risk factors for dementia – after	4.80	.78	4.66	.80	2.758	984	.006*
Signposting to sources of support – before	3.08	1.16	2.82	1.17	3.458	977	.001*
Signposting to sources of support – after	4.52	.87	4.46	.85	1.204	969	.229

Note. * indicates p<.05, ** indicates p<.001

29.16 Appendix 16: ANOVA results on differences in knowledge gained between job categories before and after training

Items	Medical and Dental		Registered Nurse		Scientific, Therapeutic and Technical		Registered Ambulance Staff		Clinical Support – HCA		Clinical Support – Others		Infrastructure Support		Others		df	F	Sig.
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD			
Recognising the signs and symptoms of dementia – before	4.14	1.00	3.43	.97	3.50	.89	3.69	.95	3.76	.91	3.00	.93	3.22	1.09	2.78	.91	7	18.58	.000*
Recognising the signs and symptoms of dementia – after	4.79	.73	4.54	.72	4.66	.65	4.63	.62	4.82	.71	4.36	.81	4.55	.77	4.51	.82	7	7.25	.000*
Understanding the impact of dementia on individuals, families and society – before	3.88	1.02	3.78	.98	3.66	1.03	3.88	.89	3.92	1.01	3.31	1.06	3.64	1.11	3.48	.82	7	7.34	.000*
Understanding the impact of dementia on individuals, families and society – after	4.93	.60	4.80	.72	4.85	.67	4.81	.40	4.98	.72	4.71	.79	4.84	.77	5.00	.75	7	2.88	.005*
Understanding person centred approaches to supporting people with dementia – before	3.74	1.06	3.46	1.02	3.43	1.11	3.50	1.15	3.88	1.02	2.87	1.04	3.09	1.22	2.98	1.21	7	18.19	.000*

Understanding person centred approaches to supporting people with dementia – after	4.90	.79	4.73	.76	4.78	.74	4.94	.44	5.00	.74	4.50	.85	4.62	.81	4.83	.81	7	7.99	.000*
Communicating compassionately with people with dementia – before	3.88	1.04	3.87	1.02	3.61	1.07	4.44	1.15	4.18	.87	3.48	1.11	3.57	1.12	3.33	1.19	7	10.65	.000*
Communicating compassionately with people with dementia – after	4.83	.66	4.87	.73	4.79	.72	5.13	.72	5.08	.69	4.71	.83	4.82	.81	4.78	.80	7	4.66	.000*
Understanding risk factors for dementia – before	4.10	1.03	3.40	1.08	3.40	1015	3.63	1.02	3.80	1.05	2.83	1.09	3.16	1.25	2.70	1.10	7	19.23	.000*
Understanding risk factors for dementia – after	4.90	.66	4.76	.73	4.83	.72	5.13	.62	4.95	.75	4.50	.83	4.68	.86	4.75	.81	7	6.86	.000*
Signposting to sources of support – before	3.34	1.09	3.09	1.10	2.87	1.07	2.81	.83	3.54	1.10	2.54	1.10	2.83	1.23	2.50	1.15	7	15.99	.000*
Signposting to sources of support – after	4.44	.81	4.54	.88	4.40	.89	4.44	.63	4.83	.76	4.27	.86	4.43	.89	4.50	.88	7	7.88	.000*

Note. * indicates p<.001

29.17 Appendix 17: Independent t-test results on differences in knowledge gained between healthcare assistants and other clinical support staff before and after training

	Healthcare Assistants		Other Clinical Support Staff		t	df	Sig. (2-tailed)
Items	Mean	SD	Mean	SD			
Recognising the signs and symptoms of dementia – before	3.76	.91	2.99	.93	9.250	487	.000*
Recognising the signs and symptoms of dementia – after	4.82	.71	4.36	.81	6.578	485	.000*
Understanding the impact of dementia on individuals, families and society – before	3.92	1.01	3.31	1.06	6.434	487	.000*
Understanding the impact of dementia on individuals, families and society – after	4.98	.72	4.70	.79	4.005	483	.000*
Understanding person centred approaches to supporting people with dementia – before	3.88	1.02	2.87	1.04	10.740	482	.000*
Understanding person centred approaches to supporting people with dementia – after	5.00	.74	4.50	.85	6.893	475	.000*
Communicating compassionately with people with dementia – before	4.18	.97	3.48	1.11	7.278	488	.000*
Communicating compassionately with people with dementia – after	5.08	.69	4.71	.83	5.315	482	.000*
Understanding risk factors for dementia – before	3.80	1.05	2.83	1.09	10.055	486	.000*
Understanding risk factors for dementia – after	4.95	.74	4.50	.83	6.179	484	.000*
Signposting to sources of support – before	3.54	1.10	2.54	1.10	9.896	478	.000*
Signposting to sources of support – after	4.83	.76	4.27	.86	7.450	473	.000*

Note. *p<.001

29.18 Appendix 18: ANOVA results on differences in knowledge gained between employing organisations before and after training

	Primary		Hospital		Community		Care Home		t	df	Sig. (2-tailed)
Items	Mean	SD	Mean	SD	Mean	SD	Mean	SD			
Recognising the signs and symptoms of dementia – before	3.28	1.04	3.21	.88	3.54	.96	3.92	1.01	3	17.391	.000*
Recognising the signs and symptoms of dementia – after	4.49	.77	4.55	.75	4.63	.71	4.86	.74	3	7.026	.000*
Understanding the impact of dementia on individuals, families and society – before	3.49	1.07	3.60	.98	3.83	.98	3.96	1.07	3	8.493	.000*
Understanding the impact of dementia on individuals, families and society – after	4.75	.70	4.84	.80	4.89	.65	5.01	.69	3	3.770	.010*
Understanding person centred approaches to supporting people with dementia – before	3.11	1.08	3.16	1.10	3.65	1.04	4.01	1.08	3	27.206	.000*
Understanding person centred approaches to supporting people with dementia – after	4.54	.80	4.75	.83	4.84	.72	5.05	.68	3	13.564	.000*
Communicating compassionately with people with dementia – before	3.67	1.07	3.60	1.05	3.96	1.05	4.14	1.10	3	9.970	.000*
Communicating compassionately with people with dementia – after	4.72	.75	4.86	.82	4.91	.68	5.09	.72	3	6.971	.000*
Understanding risk factors for dementia – before	3.22	1.17	3.08	1.15	3.54	1.03	3.86	1.16	3	16.483	.000*
Understanding risk factors for dementia – after	4.63	.78	4.72	.86	4.76	.68	5.08	.71	3	8.648	.000*
Signposting to sources of support – before	2.85	1.08	2.72	1.15	3.20	1.14	3.65	1.18	3	21.558	.000*
Signposting to sources of support – after	4.38	.83	4.50	.87	4.49	.86	4.85	.87	3	7.593	.000*

Note. * indicates $p<.001$

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