What works in dementia education and training?

How can training in dementia care best be delivered to health and social care staff? **Claire Surr** and colleagues report on the findings of a major study that set out to discover what works in providing dementia education for the workforce

For over a decade the need for the health and social care workforce to have the right knowledge and skills to deliver good quality dementia care has been recognised nationally (All-Party Parliamentary Group (APPG) on Dementia 2009; Department of Health (DH) 2009; APPG on Dementia 2013). But the question of how staff training can best be delivered has not always received the attention it deserves.

In response to the National Dementia Strategy (DH 2009) and the Prime Minister's Challenges on Dementia (DH 2012, 2015), Health Education England (HEE) led a programme of work aimed at improving dementia workforce education and development (DH 2013, 2014). One outcome of the programme was the development of the Dementia Core Skills Education and Training Framework published in collaboration with Skills for Health and Skills for Care three years ago (Skills for Health 2015) and updated last July (Skills for Health et al 2018) under the new title Dementia Training Standards Framework.

The revised framework sets out 14 subject areas across three tiers (see box 1), each with a range of learning outcomes. These list the knowledge and skills that staff working across different roles within NHS, social care and housing sector services are judged to need in order to deliver good dementia care. Existing research suggests that effective dementia education and training can lead to a range of benefits for individual staff and for organisations, but not all research has found these benefits and the quality of the studies has been variable (Kuske et al 2007; Spector et al 2013).

Overall, not enough was understood about what approaches to training were more or less effective or impactful. In response to this gap in knowledge, the "What Works in Dementia Education and Training?" study was commissioned by the National Institute for Health Research Policy Research Programme (NIHR PRP), on behalf of HEE, to shed light on effective approaches to education and training for the dementia workforce. It was conducted by a team of researchers from Leeds Beckett, Bradford and Leeds Universities.

The study addressed the following questions:

- what does existing research evidence suggest are the most effective approaches to the delivery of dementia education and training?
- what do existing dementia training programmes look like in terms of content and delivery methods?
- who is receiving dementia training and what are the barriers and facilitators to implementing it in practice?
- what are the components of impactful dementia education or training with regard to design, content, delivery and implementation?

The study drew on two evaluation frameworks that helped us to structure our data collection and analysis: Richards and DeVries' model for the evaluation of learning activities (2011), which helped us to consider the design and facilitation processes of training/learning, and Kirkpatrick's (1979, 1984) four-level model, which includes:

- satisfaction with the training – did staff find it enjoyable and useful?
- degree of learning – did their knowledge, attitudes and confidence improve?
- behaviour change – did staff change their practice as a result of the training?
- outcomes – did training lead to better quality of care and improved outcomes for people with dementia, their family members and staff?

What did we do?

We carried out activities in three inter-related work packages (WPs).

WP1: A review of the research literature on dementia education and training. This included 152 papers and has been published elsewhere (Surr et al 2017), as well as a separate review focused on the literature related to training in acute hospitals (Surr & Gates 2017).

WP2: A national online audit of current dementia training being provided to the workforce, seeking responses from health and social care providers, commissioners and training providers. The survey asked about training content, including coverage of subjects and learning outcomes in the Dementia Training Standards Framework, as well as delivery methods. We also conducted an online and paper-based survey of staff who had undertaken the dementia training reported to us in the audit, to look at impact on staff knowledge, attitudes and confidence, and any barriers or facilitators to implementing their training in practice.

WP3: In-depth case studies in 10 sites who responded to the national audit and showed signs of good training practice, based on best practice features we

Claire Surr is professor of dementia studies at Leeds Beckett University, Jan Oyebode is professor of dementia care at the University of Bradford, Cara Sass is a research assistant at Leeds Beckett University, Michelle Drury is a research assistant at the University of Bradford, Natasha Burnley is a research assistant at Leeds Beckett University, Sarah Smith is a reader at Leeds Beckett University, Sahdia Parveen is a senior research fellow at the University of Bradford, Alison Dennison is an expert by experience at the University of Bradford, Andrea Capstick is a senior lecturer at the University of Bradford and David Meads is an associate professor in health economics at the University of Leeds

Framework Subject	Number of packages that address framework subject	Number of possible learning outcomes in the subject	Average number of learning outcomes addressed by training package	Percentage of learning outcomes addressed by training package
Leadership in transforming dementia care	115	10	6.86	89%
Dementia awareness	317	11	8.91	81%
Communication, interaction & behaviour	322	18	13.91	77%
Person centred dementia care	332	11	7.85	71%
Families and carers as partners in dementia care	267	18	11.19	62%
Dementia identification, assessment & diagnosis	201	19	10.84	57%
Law, ethics & safeguarding	168	16	9.08	57%
Health & wellbeing in dementia care	270	18	10.04	56%
Living well with dementia & promoting independence	298	17	8.97	53%
Dementia risk reduction & prevention	182	10	5.03	50%
End of life dementia care	139	11	5.29	48%
Pharmacological interventions in dementia care	112	14	6.63	47%
Equality, diversity & inclusion in dementia care	241	13	6.05	47%
Research & evidence based practice in dementia care	176	9	2.09	23%

Table 1: Framework learning outcomes national audit.
KEY - Green: At least 70% of learning outcomes met. Yellow: 50%-69% of outcomes met. Pink: 49% or less of outcomes met.

identified in the literature review. These included three acute hospital trusts, three mental health or community trusts, three social care sites and one primary care site. We collected a range of data at each site including interviews with training leads and ward/home/service managers, focus groups or interviews with staff who had attended dementia training, observation of training delivery and care practice, review of the training materials and completion of satisfaction cards and short interviews with people with dementia and their family members.

An 'expert by experience' advisory group, comprising people with dementia, carers and former carers, provided support throughout the study with activities such as reviewing study documentation, developing vignettes for use in the focus groups, data analysis and development of dissemination plans.

What did we find?

While we do not have space to cover all of the work package findings, we will summarise some of the key findings that consistently emerged as elements of effective training.

We had 436 respondents to our national audit – the majority from acute hospitals and care homes - of which 241 provided data on the dementia training they delivered, including 386 different dementia training packages. Two-thirds of these courses involved some face-to-face delivery and the overall figures indicate the great diversity of what is being accessed by the dementia care workforce. Table 1 shows the different subject areas in the Dementia Training Standards Framework, how many learning outcomes there are in each subject area as well as, on average, how many of these were met by the training packages people told us about in the audit.

What Table 1 (above) illustrates is that there are a number of subject areas where, according to the survey findings, there are significant gaps in dementia training provision. Overall, the most effective training used the following methods or approaches:

Manner of delivery

The literature review, staff survey and case studies all highlighted the importance of including face-to-face delivery, whether in person or via online group tutorials, possibly accompanied by other delivery methods such as independent activities studied by e-learning or booklet, mentoring and work-based learning.

Staff should be given opportunities to meet with peers and discuss what they ➤

➤ have learned, ask questions and apply this to their own practice setting and experiences. As one staff member (social care site 042) told us: "I find personally I understand things better when it's in a training setting - there is a group of you, when you know, giving ideas and all talking together about it rather than a question on a page."

The use of interactive learning methods such as exercises, discussion, video or paper-based scenarios or case studies was also consistently valued and found to be more effective than didactic methods, where the trainer talks to people often using visual aids such as PowerPoint slides. While didactic content was acceptable, this was best used in small amounts to present key content that staff were then supported to think about in relation to their own practice through interactive activities. As a respondent (trainer, acute NHS trust 044) said:

I think practical sessions speak volumes, rather than PowerPoint presentations. Everyone's always like: "It's death by PowerPoint, isn't it?" You sit there and you just think "another slide, another slide, another slide" and you don't get people to engage with it.

Focused training

Our staff survey indicated that the most impactful training tended to cover fewer areas of the training standards framework but did so in more depth. This suggests that training programmes that cover all or most of the framework subject areas and learning outcomes in a short time are better avoided.

It is preferable for those developing or commissioning training to consider which staff groups need to know about which subjects and learning outcomes in order to fulfil their roles well, and then focus on training programmes to meet these specific needs. One way of doing this would be to map the framework subjects to staff roles, and then undertake learning needs assessments and prioritisation.

Our study also consistently found that training must be tailored to the setting type and staff group. A training facilitator (mental health trust 062) told us "we tried to make it relevant to each clinical area," while a trainer in an acute trust (044) said "…what we wanted to do was to tailor training according to staff groups".

The implication is clear. Videos, case examples and activities for care home staff should be care home-related, for instance, rather than community or hospital-related. Tailoring training to staff roles does not mean that a range of staff cannot be trained together, but materials and activities should take the mix of staff into account.

To take another example, where clinical and non-clinical staff are attending training together in an acute hospital, it is not helpful if all the case studies relate only to clinical situations. In some cases, it may be more appropriate to offer training separately to different staff groups who may have different learning needs, e.g. different educational backgrounds or English language fluency.

Experienced facilitators

Having the right skills and qualities as a facilitator also emerged as a consistent feature of impactful training. Facilitators had to be able to engage learners, make them feel comfortable in the training session, and be able to work flexibly with groups to tailor training to their needs.

Usually those trainers found to have positive impact were also experienced clinicians able to confidently support people to bring their own practice examples and challenges into training discussions. These responses give a sense of what is at stake here:

I was feeling very confident with [name of trainer]. The way she did the training is very good (social care site 042, staff focus group 1)

And obviously [name of trainer] is very personable as well as a trainer and presenter as well you know so yeah (staff member, mental health trust 062)

Key points

Training methods that worked best were:

- Face-to-face delivery accompanied by interactive learning and peer group discussion
- Clear focus on what staff need to know, tailored to their specific requirements
- Experienced facilitators capable of engaging learners
- Longer programmes with a minimum half-day duration
- Programmes with strong management support for staff to attend them.

Longer training

Our literature review indicated that longer training programmes were most likely to lead to benefits across the different Kirkpatrick levels. We found that for programmes covering a specific subject area, such as communication or person-centred care, a minimum duration of half a day (or 3.5 hours) was necessary to show measurable benefits.

We also found that where training programmes were divided into a number of individual sessions, spread over a period of time, the ideal length of each session was two hours or more. Individual sessions lasting less than two hours were less likely to be effective.

Effective training for high standards of care depended on adopting the right methods

Management support

Managerial and organisational support to attend training and then to implement learning in practice were extremely important factors in determining whether it made a difference. The sites where training appeared most impactful were those that had an organisational ethos valuing training and staff development and that encouraged staff to innovate and apply learning to improve practice.

As a company [the care home group] are really, really keen and up there to make sure the staff are fit for purpose, well trained and can deliver good care and they feel quite passionate about it I think (training facilitator, social care site 040)

So the reality is, by sort of saying that this is a must, that we facilitate people [to] have the availability to attend the training. So that's facilitated within the off duty etc for people to attend. So it's not a matter of people trying to juggle things around. We facilitate… the time for them to attend (ward manager, mental health trust 062).

We recognise that some of these components of good training practice are easier and quicker to achieve than others. Nevertheless, they are all important considerations when designing, revising or commissioning training.

To help organisations to identify and consider the key components, we have developed a "Dementia Training Design and Delivery Audit Tool" (DeTDAT) and an accompanying auditor's manual. The audit tool contains elements of good training design and delivery against which training providers and commissioners can audit existing provision, or which can be used to underpin the development of new programmes.

Free resources

Download the tool and manual for free from the study website (www.leedsbeckett.ac.uk/school-of-health-and-community-studies/what-works/) along with a further tool for mapping the learning outcomes of training programmes against those in the training standards framework. All study outputs can be found through the study website and we will continue to add further publications as they come out.

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