



All-Party
Parliamentary Group
on Dementia

Prepared to care

Challenging the dementia
skills gap

June 2009



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Foreword

There are approximately 700,000 people in the UK today with dementia. That number will double within 30 years and the financial cost of the condition will treble. The cost of dementia today is more than the cost of heart disease, cancer and strokes combined. It is clear that dementia is a health and social care challenge of a scale we can no longer ignore, and the government has recognised this with the publication of the National Dementia Strategy for England in February of this year.

Behind the statistics, however, are real people who need good care and their families who need support. Two-thirds of the care home population have some form of dementia, so it is truly remarkable that those who work in care settings receive so little training in dementia care and that the training which is available is of such variable quality. Those with dementia who are cared for in their own homes also need to be cared for by people with an understanding of their condition. However, it is evident that dementia training is scarce in the homecare workforce.

This report, following on from the All-Party Parliamentary Group on Dementia's last report on antipsychotic drugs, sets out the scale of the challenge in training the caring professions in dementia, and how it may be met. People with dementia deserve high quality care and that can only be delivered by those who understand the people they care for.

A handwritten signature in black ink that reads "Jeremy Wright". The signature is written in a cursive, flowing style.

Jeremy Wright MP
Chairman, All-Party Parliamentary Group on Dementia

All-Party Parliamentary Group on Dementia

The All-Party Parliamentary Group (APPG) on Dementia was created to build support for dementia to be a publicly stated health and social care priority in order to meet one of the greatest challenges presented by our ageing population.

The terms of reference of the inquiry

In December 2008 the APPG on Dementia announced that it would be undertaking an inquiry into the dementia care skills of care home staff and staff supporting people with dementia living in their own homes. A key stimulus for this inquiry was the previous APPG report into the prescription of antipsychotic drugs to people with dementia living in care homes. This report found the inappropriate prescription of antipsychotic drugs was in part explained by a lack of dementia care training for staff. The Group wished to build a clearer picture of the social care workforce and its readiness to deliver personalised dementia care. They wanted to understand what the barriers to workforce development are, and learn about possible solutions to these.

The inquiry requested evidence from a variety of stakeholder groups including people with dementia, carers, health and social care professionals, care home providers, academics, regulators and trade bodies. These organisations and professionals were invited to submit views on the following issues:

- What is the current readiness of the workforce to deliver personalised care to people with dementia and their families? Do you have specific evidence about workforce readiness on dementia?
- What are the barriers to improving the skills of the workforce in dementia at a national, local and organisational level?
- What do you see as the solutions to delivering system-wide workforce change in dementia skills?
- What role can your organisation play over the next two years to deliver a workforce which is better able to meet the needs of people with dementia?
- What opportunities are there to develop the professional curricula on dementia in the next two years?
- What opportunities are there for collaboration with other organisations to improve the dementia care skills of the workforce and rates of diagnosis? Who would you like to see playing a role in this work?

People with dementia and carers were invited to submit their views on the following questions:

- Was the professional(s) caring for you/person with dementia able to demonstrate knowledge of dementia and its effects?
- What care skills did they demonstrate or were lacking when providing dementia care? How did this affect your experience and why?
- What do you think are the important skills that professionals should have to enable them to care for a person with dementia?
- Would you like to be involved in the development of the skills of the local social care workforce? Yes or No? If yes, how would you like to become involved?

The Group also heard evidence from organisations and individuals in two oral evidence sessions held at the House of Commons on 17 and 18 March 2009. These sessions were overseen by Jeremy Wright MP, David Drew MP, Tim Farron MP, Linda Gilroy MP, Baroness Greengross, Joan Humble MP, Gordon Marsden MP, Edward O'Hara MP, Dan Rogerson MP, David Taylor MP and Phil Willis MP.

Witnesses

Witness	Organisation
Brenda Walker	Dementia Care Trainer
Maria Parsons	Lead Dementia Adviser, Sanctuary/Executive Director, London Centre for Dementia Care
Steve Milton	Consultant and Dementia Care Trainer
Sally Knocker	Director of Communications, National Association for Providers of Activities for Older People (NAPA)
Ruth Sutherland	Chief Operating Officer, Alzheimer's Society
Diana Tonnison	Carer
Gillian Dalley	Chief Executive, Relatives and Residents Association
Sheena Wyllie	Director of Dementia Services, Barchester Healthcare
Helen Joy	Chief Executive Officer, Brunelcare
Sharon Blackburn	Managing Director, Heart of England Care
Lucianne Sawyer CBE	Representing home care services
David Walden	Director of Strategy, Commission for Social Care Inspection (CSCI)
Annie Stevenson	Programme Director for Older People, Social Care Institute for Excellence (SCIE)
Andy Tilden	Head of Standards and Qualifications, Skills for Care
Simon Williams	Lead on Dementia for Association of Directors of Adult Social Services (ADASS) and Director of Adult Social Services at Merton

Acknowledgements

The Group would like to thank Alzheimer's Society for its assistance in organising the oral evidence sessions and with the writing of the report. We would also like to thank the witnesses who took part in the oral evidence sessions, as well as those individuals and organisations that submitted written evidence.

Inquiries

Please direct any comments or queries that you may have about this report or about the Group to the Secretariat at appg@alzheimers.org.uk or, alternatively, contact the Chairman, Jeremy Wright MP, at the House of Commons, London, SW1A 0AA.

Executive summary

In this report the All-Party Parliamentary Group on Dementia examines the readiness of the social care workforce to deliver personalised care to people with dementia.

The Group heard that, as a whole, the social care workforce has a very limited knowledge of dementia and is therefore not ready to provide high quality dementia care. There are some examples of excellent practice demonstrating that, given the right support, staff can improve quality of life for individuals with dementia. However, there is also evidence of poor practice, failing to respect the person as an individual and not understanding how to prevent or respond to behaviour that challenges.

Research data supports anecdotal evidence that the proportion of staff receiving dementia care training is low, even among those working in specialist dementia services. For example, around one third of care homes with dedicated dementia provision report having no specific dementia training for staff.¹

The negative attitudes surrounding dementia, which incorporate ageism, have acted as a barrier to workforce development in terms of individual practice and public policy. The mistaken, but lingering, belief that attempts to improve well-being in people with dementia are hopeless has resulted in little priority being assigned to developing a workforce with appropriate skills. In addition, the significant under-recognition of dementia (only one third receives a formal diagnosis¹) provides an inaccurate assessment of workforce training needs.

Despite dementia care requiring a high level of competence, particularly emotional and empathetic skills, the workforce is perceived to have an inappropriately low status that is exemplified by poor employment terms and conditions and lack of career opportunities. This contributes to a high staff turnover, which militates against workforce development and acts as a huge disincentive to employer investment in the workforce.

Although training alone is insufficient to improve the care provided to people with dementia, the very low level of training in dementia is a significant barrier. The lack of clear regulations has led to confusion about what training should be provided and allowed some employers to provide minimal levels of training. The absence of a standardised curriculum and accreditation system for dementia care trainers has also contributed to the variable quality and ad hoc nature of training. The number

¹ National Audit Office, Improving services and support for people with dementia, 2007

of service providers requesting half day training programmes, wholly insufficient to enable staff to develop their practice, is a particular concern.

It was made clear to the Group that training would not improve the quality of life for people with dementia in organisations that did not value good care. Care staff are frustrated that they cannot put in place the strategies that they have learned because working practices do not allow it. Both service managers and local authority commissioners may be responsible for placing barriers in the way of good practice, including inflexible daily routines and reward systems that focus on physical tasks rather than quality of interaction or outcome for the individual with dementia.

Funding problems are also perceived to be a barrier to workforce development. Not just because of the cost of training, but also because budgetary restrictions lead to poor practice such as 15 minute home care visits. The failure of some local authorities to reward good providers by paying a premium for services that reached higher standards was criticised. Furthermore, there was discussion on whether Commission for Social Care Inspection (CSCI) had taken appropriate action against services that did not meet National Minimum Standards. The lack of support from specialist mental health services that could provide support and training to staff is highlighted as another barrier to workforce development.

Solutions must be based on an acceptance of the level of skill required to provide good quality dementia care. The majority of witnesses feel that dementia care training should be mandatory for social care staff. Different groups of staff are likely to require different levels of training but given the high prevalence of dementia amongst recipients of social care, all staff need a minimum of dementia awareness training. Training sessions must form part of an ongoing support and management programme which encourages reflective practice.

The social care regulatory system plays a vital role in supporting the workforce, by setting training standards and helping to develop organisations that enable staff to achieve high standards. Witnesses discussed the need to achieve a balance between standards that relate to outcomes for people using services and standards that relate to inputs necessary to achieve those outcomes.

Given the high proportion of people with dementia amongst older people using social care services, many witnesses feel dementia specific regulatory standards are appropriate although some question this. However, the National Dementia Strategy for England (NDSE) recommendation that review of National Minimum Standards should be informed by new dementia core competencies in occupational training highlights that dementia care skills must be a key concern for the Care Quality Commission (CQC)².

2 Department of Health; Living well with dementia: a national dementia strategy, 2009

In order to overcome organisational barriers, all staff involved in providing services for people with dementia need to understand good person-centred care and be determined to implement it. Leaders within service providers are crucial to setting the right tone and providing guidance and support to care staff. Developing leaders with good generic management skills as well as good dementia care skills is seen as an important solution. But witnesses feel training to improve understanding of dementia should extend beyond direct care providers to include commissioners and others within local authorities. They play an important role in creating working practices that enable good outcomes for people with dementia.

Witnesses feel that an accreditation system for trainers is necessary to remove inconsistencies in quality. Development of dementia core competencies, as recommended in the NDSE, should be taken forward as a priority so there is clarity on the outcomes training should achieve. The new Qualifications and Credit Framework (QCF) provides an opportunity to develop a qualifications pathway specific to dementia, which could present one solution to the current lack of career opportunity.

Although tight budgets will be an ongoing problem, development of a qualifications pathway specific to dementia, within the QCF, could also help to tackle funding issues. Service providers could access Train to Gain funding for training undertaken as part of this pathway. Greater clarity over the levels of training that should be provided alongside improving commissioners' knowledge of what good dementia care looks like may help to improve understanding about what it costs to provide services to people with dementia. This could lead to the improvement in relationships between commissioners and service providers that witnesses identified as necessary.

Further solutions identified included improving links with external services, in particular for older people's mental health services to provide support and training to social care staff. Better joint working would provide opportunities to increase efficiencies and improve outcomes for people with dementia. For instance commissioning social care services to provide outcomes of concern to the NHS – for example reduction in falls.

Finally, it is recognised that the personalisation agenda raises a new set of questions about the training needs of the workforce. There was much debate about how to balance the need for safeguards with the opportunities for choice and control presented by the personalisation agenda. The Group agrees that it is vital for people with dementia and carers to be involved in any debate about taking forward the personalisation agenda and, in particular, issues around training.

The Group makes the following recommendations to take forward the development of the dementia care skills of the social care workforce:

- The Group urges the Department of Health to prioritise early work on achieving Objective 13 of the National Dementia Strategy for England – ‘An informed and effective workforce for people with dementia.’
- We need to move towards a situation where the workforce as a whole demonstrates effective knowledge and skills in caring for people with dementia.
- It is important that workforce development programmes are carefully designed to meet the needs of care staff and ultimately improve the lives of people with dementia.
- There must be greater regulation of dementia care trainers to combat the current inconsistencies in quality. We recommend the development of a kitemarking system.
- There must be greater recognition of the level of skill required to provide good quality dementia care as well as recognition of the importance of maximising the quality of life of individuals who develop dementia.
- It is vital to develop effective working relationships between commissioners and service providers that are based on a good knowledge of what good dementia care is and what is required to provide it.
- Good dementia care is reliant on well integrated working between social care and healthcare and this must be improved.

Introduction

1. The number of people with dementia in the UK is growing. 700,000 people in the UK have dementia and this is forecast to increase to 940,000 by 2021 and 1,735,087 by 2051, an increase of 38% over the next 15 years and 154% over the next 45 years.³
2. Two-thirds of people with dementia live in their own homes (approximately 460,000 people) with one third living in care homes (approximately 240,000 people). At least two-thirds of people in care homes have dementia. There are approximately 18,450 care homes in England and 4,897 home care agencies providing support to people to live at home.
3. People living with dementia come into contact with a number of health and social care professionals, including GPs, old age psychiatrists, social workers and care staff. Following discussions within its membership and with stakeholders, the Group decided to limit the scope of this inquiry to the skills and training of social care workers. It was felt this approach would produce an inquiry report that had a tightly focused approach, could examine areas of concern in greater detail, and produce more robust recommendations.
4. Furthermore, the Group's previous inquiry into the prescription of antipsychotic drugs found that poor training of social care staff was a contributing factor to the inappropriate prescription of antipsychotic drugs to people with dementia living in care homes. The evidence of low levels of training among social care staff that emerged during the antipsychotic inquiry was a key stimulus to undertaking the present inquiry into the social care workforce.
5. Social care workers, both in people's own homes and in care homes, may help with aspects of personal care: getting the person up, washed and dressed; changing bedding; doing laundry; supervising meals to make sure the person eats properly; and putting them to bed at night. With the introduction of the personalisation agenda, the government is promoting individual budgets whereby people have greater choice and control over the services that are purchased to support them. This may change the type of support social care workers provide and also raises critical questions about the reliability of the providers independently commissioned for people at risk.

³ Knapp M et al, Dementia UK: The full report, 2007

6. The symptoms of dementia mean carrying out relatively simple care tasks requires a good understanding of the condition and its effects. The different types of dementia affect individual people differently and also change over time, so staff must have the ability to develop individual responses, rather than having a one-size-fits-all response.
7. Alzheimer's Society's written submission explains the impact of dementia: 'The impact of dementia in each individual is profound. Dementia can affect a person's memory, speech, and ability to complete activities of daily living. Communication problems can be a particular challenge in the care home setting, and many people with dementia communicate through behaviour that may be seen as challenging, for example hitting out. In time, dementia leads to increased disability and possibly immobility, making the use of hoists necessary for safe transfer. Good skin care is also vital to prevent pressure sores. People with dementia may also experience hallucinations and delusions.'
8. The inadequacy of the care services provided to people with dementia has been the subject of numerous reports over the years. The growing recognition that much can be done to maintain the quality of life of people with dementia means that services must go beyond basic support and aim to promote independence, well-being and the maintenance of abilities. Serious concerns have been raised over whether the workforce has the right training, support and leadership to enable it to provide this level of support. The National Dementia Strategy for England recognises that 'the need for workforce development is profound'.⁴
9. Despite the very large proportion of care home residents and home care recipients that have dementia and the complexity of their needs, there is no explicit requirement for care staff to have training in dementia care.
10. The King's Fund estimates that the cost of dementia in England to the NHS, local authorities and individuals will rise from £15 billion now to over £23 billion by 2018. The same report also estimates that by 2027, spend on dementia will make up 75 % of mental health costs.⁵ The National Audit Office (NAO) has found that the inadequate response to dementia results in a significant amount of money being wasted. For example, in a case study in Lincolnshire, partnership between agencies to deliver an improved dementia community response secured a saving of £6 million a year from one hospital.⁶

4 Department of Health, Living well with dementia: a national dementia strategy, 2009

5 McCrone P, Knapp M, et al, Paying the price: The cost of mental health care in England to 2026, King's Fund, 2008

6 National Audit Office, Improving services and support for people with dementia, 2007

11. There are a number of factors which represent significant opportunity to transform the dementia care workforce. These include the National Dementia Strategy for England (soon to be followed by a Welsh strategy and another in Northern Ireland), establishment of a new regulatory body (Care Quality Commission) and a review of standards, as well as the development of new qualification structures. It is therefore important to assess the current quality of the workforce, the barriers to improvement and the potential solutions.

Structure of the report

12. In section 1 we set out the evidence received on the readiness of the workforce to deliver person-centred care to people with dementia. Section 2 discusses the barriers to workforce development and section 3 explores some of the solutions. Finally, in section 4, we set out our conclusions and recommendations.

Evidence

13. We received more than 240 written submissions from organisations and individuals, and we heard key evidence in two oral evidence sessions. Most of this evidence will be published in full in a separate report.
14. All the evidence was collated and the key messages extracted. These key messages form the basis of the report and are grounded in examples, with the use of verbatim extracts and written evidence to support the arguments being made.

1 The current readiness of the workforce to deliver personalised care to people with dementia and their families

15. The experience of people with dementia and carers tells us much about the readiness of the workforce to deliver personalised care. This is supported by information from national reports on standards of care and levels of training.

The varying levels of readiness among the workforce result in some people with dementia receiving an unacceptable level of care

16. Evidence from people with dementia, carers and organisations depicts a workforce that varies hugely in their knowledge of both dementia and how best to support those living with the condition, as well as in the level of empathy, warmth and understanding they demonstrate. These submissions from carers and people with dementia illustrate good and bad experiences:

‘The busybodies leave me feeling taken down a peg ... The busybodies rush through in a hurry, disrupting my desire to start my day at my own pace ... When I think about the relationships I had with people I worked with, I knew those people and, in comparison, I don’t know these people at all. If I said to one of those girls, ‘What is it like for you?’ they would just say ‘What?’ They don’t want me to talk to them. I suppose somehow I actually feel insulted by it all. They talk to me like a child and I don’t like it. Some people even act as if I might be contagious, a thing to be handled carefully with rubber gloves.’⁷

‘The care workers who supported my partner at home communicated respect for him as an adult and were very gentle and patient, taking time

7 A carer, included this quote, written by his wife, in his submission of evidence. The quote is from Dartington A and Rebekah Pratt R (2007) My Unfaithful Brain – a journey into Alzheimer’s disease. In: R Davenhill (ed) Looking at later life, a psychoanalytic approach to depression and dementia in old age, pp. 283–97. London: Karnac.

to explain what they were going to do step by step and gaining his cooperation, eg getting him to look in the mirror to see for himself he needed a shave, having him “wash your front while I do your backside”. As it is very easy for him to become confused about what is going on and frustrated when he can’t do things himself, this approach enabled them to give intimate personal care without him getting antagonistic or distressed. They also took time to build a relationship, to chat and joke with him, have a cup of tea with him before taking him for a wash. They listened and responded to his expressions of preference (eg not liking water from a shower directly on him). They picked up on his favourite verbal expressions and interests. They also communicated confidence in their own caring skills which he picked up on a non verbal level and enabled him to trust them.’

‘But there wasn’t any real attempt that I could see to engage with individuals with dementia or talk with family visitors about strategies or tactics, if you like, about things to try. Therefore they weren’t able to anticipate possible problems that might occur if an individual with dementia was presenting awkward behaviour that might get worse unless an effort to find and understand the cause was attempted. There was irritation shown by staff with those who might continue to shout out loud which resulted in them walking away from them and leaving them to it.’

‘Patience. Interest in the person with dementia as a personality. Tolerance of foibles. Dignity. Kept him clean and well dressed. Provided chiropody and outings. Talked to him and involved him in activities. There staff I have seen show understanding, quiet assertiveness, humour, persuasiveness, patience, vigilance. My experience to date has been positive.’

17. The Social Care Employers Consortium (SCEC) reports that many staff who work within the community start with little or no care experience, so even fewer have a knowledge of dementia. They explain that a lack of knowledge of dementia can lead to staff being frightened of individuals who have dementia or ‘blaming’ them for their actions:

‘Sadly, staff do not know how to gently coax someone with dementia to accept the support they need. Staff do not seem to understand the personality changes that can occur and, as a consequence, they become very upset when a service user is unpleasant or rude to them, not realising this is part of the condition.

It is also evident that some support workers are “frightened” of supporting someone with dementia, especially if they are exhibiting aggressive or challenging behaviour.’

18. Particular problems described in the evidence include a failure to provide opportunities for activity, to find out about a person's likes and dislikes and to engage with individuals who have dementia as fellow men and women:

'Care home staff and staff supporting people in their own homes are poorly prepared for this role. This is due to a lack of understanding about:

- What it is like to live with dementia
- That living with dementia means living with dementia
- That care for a person with dementia involves care for a living, human being who has human needs for affection, attention, engagement, activity and occupation.
- That care for a person means care for the whole person, their physical, psychological, emotional, social and spiritual well-being.'

(Bradford Dementia Group, written submission)

'Other research in 12 homes found that over a six-hour period the median resident spent less than two minutes in conversation (or other forms of communication) with staff or other residents, outside of care tasks.'

(Alzheimer's Society, written submission)

19. As stated by National Association for Providers of Activities for Older People (NAPA), boredom, frustration and isolation increase the risk of behaviour that care staff may find challenging:

'People with dementia who are bored and do not have "people to see, places to go and things to do" are more likely to resort to behaviour which others find challenging in an attempt to get their needs met.'

20. This fits with the findings of the Group's previous inquiry into the prescribing of antipsychotic drugs in response to the behavioural and psychological symptoms of dementia. The evidence submitted to that inquiry shows that a lack of awareness of good dementia care among staff is one of the causes of this significant problem. There is an increased risk of behaviour that challenges if staff do not understand how to meet people's need for activity and how to provide good person-centred care. Untrained staff are also less likely to know about responses to this behaviour that do not rely on antipsychotic drugs.

21. A number of submissions from carers to the current inquiry highlight disturbingly poor practice, which show a complete lack of respect and are in the worst cases dehumanising.

'A male resident (an ex-bank employee) in the lounge after supper kept shouting out loudly that he wanted to go to the toilet. The resident was unable to walk and was chair-bound all day. The male nurse in the lounge

eventually got up from the table and asked what the resident wanted. When the resident repeated he wanted to go to the toilet the nurse told the resident that he had a pad on and he could do it in that.'

'My mother spoken to rudely by a manager "sit down and shut up", but this was reported and action taken ... overheard in another Unit. "If you don't eat that I will not look after you tonight."

Conclusion

22. **This evidence suggests the workforce as a whole is not ready to deliver personalised care to people with dementia and their families. There are examples of excellent practice by skilled and dedicated staff. However, it appears that low levels of knowledge of good dementia care are far too common. There are examples of a basic failure to treat the person with dementia as a fellow individual, with a need for social interaction, respect and warmth.**

Data from national reports confirms the generally low levels of dementia care knowledge among the workforce

23. Submissions include information from national reports and regulatory activity. The Commission for Social Care Inspection (CSCI) report 'See me, not just the dementia' looked at the experiences of people with dementia living in care homes, with a particular focus on whether their care offers dignity and respect.⁸ It employed the Short Observational Framework for Inspection (SOFI) tool which provides a systematic framework for making observations about care and the lived experience of care home residents. CSCI reported encountering pockets of good practice in dementia care, but also problems with care planning and a sense that homes were only able to meet a 'generic' set of needs. It highlighted the lack of understanding of dementia among staff in the poorer homes:

'The report also documented some poor practices around communication, with impersonal assistance and a task-oriented approach undermining people's sense of dignity and resulting in them being passive and silent. Importantly, the report showed that even "neutral" or task-based interaction could have a negative impact on people with dementia. In addition, inspectors found that some staff gave insufficient attention to – or had a lack of awareness of – the needs of everyone living in the home, especially those with the greatest needs. This was often because many care staff have a lack of understanding about dementia and receive only limited training.'

-
24. Laing and Buisson's recent report into the residential dementia care market contains concerning data on the low levels of dementia care training in the care home workforce⁹:

'Around one third of care homes with dedicated dementia provision reported having no specific dementia training for staff. There is a very wide range of training in dementia, from relatively informal to fully accredited courses/professional qualifications. There is a wide array of training and education providers. Overall, arrangements for specific dementia training in care homes seem rather fragmented and often ad hoc.'

25. Alzheimer's Society's submission refers to research reports assessing the level of training among social care staff:

'Mozley (2004)¹⁰ found only 8% of nursing/care assistants had received in service training relating to psychiatric/psychological needs of residents which included dementia care. Hughes (2008)¹¹ found 14% of the 254 care home staff from 30 homes responding to his questionnaire had prior training in dementia care.'

26. The UK Homecare Association (UKHCA) publication *Who cares now?* gathered data about the independent home care workforce.¹² Care workers were asked whether they provided home care to people with a range of different needs and whether they had received training in that area.

- More than two-thirds (69%) of workers reported providing care to people with dementia and 30% said that they had received training in the area.
- So less than half of the care staff providing care to people with dementia had received any training, despite the specialist skills required.

27. Buz Loveday, Dementia Care Trainer, explains the impact of this lack of training on the readiness of the workforce in her submission:

'Many staff attending our training courses have had no prior training on dementia, despite many of these individuals having worked in the field for very many years. While many staff now have basic NVQ level 2 qualifications, these do not tend to equip them to understand anything about dementia. At the beginning of most training courses I run, I encounter profoundly mistaken beliefs and unhelpful attitudes about dementia.'

9 Laing and Buisson, *Dementia care services UK market briefing*, 2009

10 Mozley, Caroline et al, *Towards quality care – outcomes for older people in care homes*, 2004

11 Hughes, J et al., *Care staff working with people with dementia training knowledge and confidence*, 2008

12 McClimont B and Grove K, *Who cares now? An updated profile of independent sector home care providers and their workforce in England*, UKHCA, 2004

Conclusion

- 28. Dementia is a complex condition and providing good care requires a high level of skill and empathy. Yet despite this, the evidence shows levels of training are low, even in specialist dementia services, and this is reflected in the lack of knowledge and attitudes of many social care staff. This suggests a misguided belief that specialist training is not required to provide support to people with dementia. The result of this is a vulnerable group in society experiencing nothing like the standard of care they deserve.**

2. Barriers to improving the skills of the workforce in dementia at a national, local and organisational level

29. The evidence identifies numerous barriers to improving the skills of the workforce. Many are interconnected. Witnesses highlight that the situation will only improve if a comprehensive approach is taken, which addresses challenges emanating from the range of individuals and organisations involved in systems of dementia care.

Negative attitudes regarding dementia and older people in general

30. The evidence in the previous section describes the lingering assumption that nothing can improve the well-being of people who have dementia. Submissions describe how these negative attitudes can hinder the development of good care practices:

‘Sadly, the stigma of dementia produces nihilistic attitudes and resulting expectation that only minimum standards of care are sufficient. Providing care is often seen as a process of delivering the basic requirements of human existence, those of food, fluid and hygiene. Tragically, there is evidence in care homes and hospitals that even these standards are not achieved (Age Concern, 2006).’ Royal College of Psychiatrists, Faculty of Old Age Psychiatry.

‘As well as hindering the development of policy and resources, negative public attitudes about dementia will also affect individual practice. Research has shown that the disconnect between research findings on good practice and actual practice is in part due to negative perceptions of dementia held by long term care staff (Brodaty et al, 2003, in Ayalon (2009)) as well as inaccurate knowledge regarding dementia care (Helmuth, 1995; Thurmond, 1999, in Ayalon (2009)).’ Alzheimer’s Society

31. Negative attitudes partly explain why two-thirds of people with dementia do not receive a formal diagnosis.¹³ The following submissions describe how

¹³ National Audit Office, Improving services and support for people with dementia, 2007

under-recognition of dementia leads to an underestimation of the need for workforce development and care staff who are not made aware of the actual needs of the people they are caring for.

‘Dementia is already under-identified within the population at large care homes and with people who have learning difficulties are getting older and developing dementia. The level of under diagnosis can lead care providers into a false assumption that they do not ‘work with people who have dementia’ and therefore it is not seen as a training need, particularly in the early stages of dementia when someone may present as ‘forgetful’.’ (Association of Care Training and Assessment Networks (ACTAN), written submission)

‘As opposed to physical examinations, mental state examinations are still not regarded as of paramount importance by people making assessments of people needing care whether in a care home or at home. The result is that people doing the caring are frequently quite unaware that a person has a dementia as well as several other health problems with all the associated implications.’ (Dr Nori Graham, Emeritus consultant in old age psychiatry, written submission)

32. The evidence identifies ‘dementia-ism’ and ageism as related barriers.

‘I think the deeper issue here is that we have a real problem with age discrimination: poor attitudes towards older people who are not valued in our society and I think each body reflects the difficulties around those issues. I think the regulatory system struggles with that as well.’ (Stevenson, 18 March, oral evidence)

‘Care work takes place within an ageist (Department of Health, 2001) and dementist (Banerjee et al., 2007; Macdonald and Denning, 2002) health care system such that people with dementia are viewed as not meriting care.’ (Bradford Dementia Group, written submission)

33. In Person-centred dementia care: making services better (2007), Dawn Brooker wrote: ‘Stephen Post (Post 1995) described Western society as hyper-cognitive. This is a special type of ageism, the victims of whom have cognitive impairment. There is also a prejudice about people with dementia because of the association with madness and psychiatric disorder that the label brings. ... This discrimination is evident in service provision, resource allocation, research funding, media coverage, policy priorities, professional training and status, and the pay of care workers’.¹⁴

¹⁴ Brooker D, Person-centred dementia care: making services better 2007

Conclusion

34. **Negative attitudes about dementia and the low value society places on older people and people with cognitive difficulties act as barriers to workforce development. This is exacerbated by slowness to recognise or diagnose dementia which means that, by the time this situation is accepted, the challenges faced by care staff and others will be even greater. Although we know much more now about how to promote quality life in people living with dementia, this has yet to consistently feed through to the training of staff and care practice.**

The inappropriately low status of the dementia care workforce

35. The low status assigned to people living with dementia is matched by the low status of the dementia care workforce. Submissions explain how this hinders workforce development through lowering morale and motivation and increasing turnover:

‘Staff who work in social care, by association, have low status and low pay. The turnover of staff is high, motivation is low and it is hard to improve and upgrade skills when the workforce has such an unworthy profile.’
(Guideposts Trust, written submission)

‘The majority of the workforce are low paid, experience poor work conditions i.e. long hours, understaffing, high workload etc and have limited career progression opportunities.’ (Admiral Nurses, written submission)

‘The nature of the work, the lack of a coherent career structure and pay rates all appear to contribute to the high turnover rates that characterise the care sector.’ (National Care Forum, written submission)

36. CSCI report turnover rates of care workers to be 23.2 % in nursing homes, 20.5 % in residential homes and 22 % in home care.¹⁵ This militates against the development of a skilled and experienced workforce. It also prevents the continuity of care that should be a core characteristic of dementia care. The UK Homecare Association (UKHCA) explains that high turnover ‘prejudices the completion of qualifications such as NVQs, thereby reducing the effectiveness of training funding.’ It also costs the social care sector an estimated £78 million annually, through the loss of workers who have gone through the initial training programme, which costs around £980 per person.

15 Commission for Social Care Inspection, The state of social care 2008, 2009

37. The high staff turnover is a huge disincentive to employers to invest in training and development, yet lack of those opportunities may increase turnover. There is also no career path within dementia care, particularly for people who want to carry on providing direct care, which witnesses identified as a barrier to development:

‘Also at the national level the lack of value that society puts on the role of unqualified care staff has a negative impact on motivating staff to develop their skills and this is made worse by having no obvious career pathway.’

(Dr Amanda Thompsell, Consultant Old Age Psychiatrist, Care Homes Support Team, Dulwich Hospital, written submission)

‘A care worker has little prospect of developing a career in care and little incentive to strive for personal development or higher standards. That we value carers so little is an indication of the lack of value we place on the lives of people with dementia.’ (Royal College of Psychiatrists, written submission)

38. However the British Medical Association (BMA) points out the difficulty in implementing a standardised career structure within a service provided primarily by the private sector:

‘The majority of care homes are in the independent sector which creates a significant barrier to standardising the skills of the care home workforce and providing training, and adequate support. This would be problematic if a standardised pay structure were imposed. However, such a pay structure would create an opportunity to ensure that certain levels, such as NVQ 3 were reached before a member of staff could rise to the next pay level.’

Conclusion

39. **The Group concludes that the low status given to people working in dementia care is a barrier to workforce development as it creates low morale and motivation. Although staff may be intrinsically motivated to improve skills and gain qualifications, the lack of a standardised career path with associated salary increases means this incentive is often not available. The high turnover rate is also a disincentive to organisations to invest in workforce training and development.**

Low levels of training in dementia care

40. Witnesses identify the low levels of training provided in many services as a key reason for the lack of workforce readiness (see also quote from CSCI, paragraph 23):

‘Insufficient training is a major issue contributing to this lack of workforce readiness. Anecdotal evidence shared by inspectors during the course of my work with them indicated that many direct care staff have had no training on dementia at all, or have had woefully insufficient training – such as being shown a DVD or attending a half-day workshop including dementia amongst other topics.’ (Buz Loveday, Dementia Trainer, written submission)

Lack of regulatory standards relating to training in dementia care

41. It is argued that the lack of regulatory requirements directly specifying dementia care training results in the inappropriately low levels of training reported. As evidenced in paras 24–26 a significant proportion of staff receive no dementia care training at all. In addition, the lack of clear standards allows some dementia care service providers to give the bare minimum of training. Steve Milton (Dementia Care Trainer) explained that training is often requested in response to a particular incident rather than as part of a structured programme. The high level of requests for half day training sessions is of particular concern to trainers giving evidence. It is perceived that service managers or commissioners feel this allows them to ‘tick the dementia training box’. However, because of the complexities of the condition as described in paragraph 7, it is impossible to make a difference to care in such a short space of time and with such an insufficient approach.

‘There is no clarity about what training sessions should cover. In many instances organisations seem to be able to get away with half day training sessions which seem to satisfy the requirements for registration as a dementia unit. This is woefully inadequate. We need clear guidelines on minimum standards that can be enforced.’ (Walker, 17 March, oral evidence)

42. Others services find it very difficult to understand how much training they should be providing and what that training should cover. Alzheimer’s Society Home from home (2008) report found one in five care home managers reported that ‘finding information about the type of dementia care training to provide’ to be one of the top three challenges in providing good dementia care.
43. David Walden of CSCI recognises that the training requirements are ‘very general and generic.’ He agrees with Joan Humble MP’s assessment that it is time to review the National Minimum Standards in light of the fact that most care home residents have dementia, while questioning how much

specificity was helpful. However, many witnesses believe the lack of clear standards to be unhelpful:

‘The only way in which system-wide workforce change will happen is if some form of training is made mandatory – as with moving and handling. Otherwise we will have some employers not conforming. For organisations that are registered to work with people with dementia, compliance must be part of the CQC (Care Quality Commission) inspection process.’
(Buckingham County Council, written submission)

‘The most pressing issues are that training is not mandatory, there are no recognised national standards and no consistent quality monitoring.’
(Anchor Trust, written submission)

‘Unfortunately the induction which is recommended by Skills for Care does not include anything at all on dementia, neither does the NVQ2, which is what the staff are required to be registered for as soon as they are actually out working, and that is enormously unhelpful.’ (Sawyer, 18 March, oral evidence)

44. Andy Tilden of Skills for Care also explains that they had not expected the ongoing delay in the registration of care workers by the General Social Care Council (GSCC). Skills for Care had felt that although general induction standards do not require specific dementia standards, registration of care staff working in dementia services would require induction training to cover dementia. The Adult Social Care Workforce Strategy has announced that the GSCC will be developing a voluntary register of home care staff from early 2010, with the expectation that it becomes compulsory. No details are currently available on the criteria for registration.

Conclusion

45. **It is clear that the low level of training provided to the majority of staff in this skilled area of care makes it difficult for the workforce to provide the right level of support. The lack of regulatory requirements stipulating the level of dementia care training staff must receive is a strong disincentive to any structured development or even maintenance of standards as well as permitting the provision of inappropriately low levels of training. The situation is not helped by the delay in registration of care workers by the GSCC.**

Core competencies to guide the content of training need revision

46. The Skills for Care Dementia knowledge set is not seen to provide adequate guidance for organisations that want to provide good quality training for their staff. Steven Milton argued that it is a good start but does not provide sufficient guidance on what training should cover.
47. Andy Tilden notes that the dementia knowledge set may not be appropriate for organisations already providing a high standard of care, but argues it may be helpful to some of the sector:

‘As we have heard, the knowledge set provides the absolute baseline. Our understanding of the sector is a little like a pyramid. You have providers in the room who are at the top of the pyramid and I perfectly accept that the baseline of our knowledge set does not reach the levels that the providers in the room are wanting, but there will be lots of parts of the sector out there that would be extremely stretched by that particular knowledge set.’
(Tilden, 18 March, oral evidence)

Characteristics of the workforce

48. Low levels of literacy and numeracy are potential barriers to developing skills and benefiting from certain types of training. Witnesses identify the need to be aware of this and adjust training accordingly. The result of poor literacy among the workforce may be inadequate recording, which CSCI has identified as a significant problem in care services.
49. The social care workforce is also characterised by the high numbers of staff from overseas. This has both benefits and disadvantages in terms of the quality of care provided. Witnesses highlight that having a non-British background prevents care staff from engaging with residents on some aspects of British culture because they do not know about them. Sally Knocker gave an example of how otherwise good Filipino care workers were not able to engage residents in reminiscing about Woolworths.

Conclusion

50. **The Group concludes that the dementia knowledge set may clarify learning outcomes for some organisations, but it is not appropriate for all. Development of a common curriculum should take account of the characteristics of the workforce and should address issues of delivery and engagement with a highly varied workforce – some of whom may need a much stronger social grounding to improve interaction with patients.**

The lack of a regulatory system accrediting dementia care trainers

51. In addition to a lack of standards around the level and content of training, witnesses explain there is no regulation of the trainers who are providing dementia care training. In response to the Chairman's question on who regulates training providers, Andy Tilden says:

'We are not a regulator but Ofsted would be the regulator of those trainers who access government funding. The Sector Skills Council responsible for training is Life Long Learning UK but there are no clear regulations. There is training quality standards developed by the Sector Skills Council for different sectors but there is nothing specific in the way I suggest your question is geared in that particular respect.' (Tilden, 18 March, oral evidence)

52. A number of organisations' training schemes were commended but the reality is anyone can set up as a dementia trainer. In the light of this, witnesses are concerned about the variable quality of training provision.

'I think your question is asked because you know it is very patchy. I know you have had some good trainers here but there are lots of people out there who are, I guess, making money not really with the value base that we would like.' (Tilden, 18 March, oral evidence)

'There is an absence of dementia care trainers that have a background of working with people with dementia in a person-centred way. Many basic dementia courses are delivered by trainers who may have an understanding of the impact of the condition, and may deliver this within a medical model. In order to provide truly effective, person-centred and holistic training, trainers should have either occupational competence or have close links with a specialist care provider who provides high quality services for people who have dementia.' (ACTAN, written submission)

Conclusion

53. **The effectiveness of training relies heavily on the quality of the trainer so it is of concern that there is inconsistency in the quality of training providers. The lack of accreditation or regulation of training providers is without doubt a causative factor behind this inconsistency.**

Organisational cultures that do not value good care

54. Although lack of training is seen as a barrier to workforce development, it was made clear to the Group that simply sending staff on training courses

without creating an environment which supports good care makes no difference to people's well-being. An organisational culture that does not value good care is a barrier to workforce development. Steven Milton argues that training can be counterproductive in these circumstances:

'The most important thing from my perspective is that training on its own is worse than useless, to be honest, if it is taking place within an environment which is not supportive of the need to change and the need to provide good care. What you end up with is a disrupted and disenfranchised workforce.' (Milton, 17 March, oral evidence)

55. A number of witnesses spoke of the frustration of care staff who have developed excellent dementia care knowledge but find they cannot implement what they have learnt because organisational barriers do not allow it.

56. The evidence shows us that if managers do not understand what good dementia care is they cannot provide the right guidance and positive reinforcement. Also, the organisation must have working practices that enable good care to happen, for example flexibility in routines. Other witnesses explain that the organisation must treat its staff in a caring, person-centred way if they are to expect them to treat service users similarly.

'My experience is that there is real enthusiasm for information from care workers regardless of their background and education. Often the problem is that the senior people lack training and information and when the care workers attempt to use their new knowledge they get little support and complain there is never enough time to carry out real personalised care.' (Dr Nori Graham, Emeritus consultant in old age psychiatry, written submission)

'The culture of care within many dementia care settings can inhibit change. The Division of Dementia Studies at the University of Bradford aimed to assess how and if education in dementia care had a positive impact on students or their practice through a small scale, informal evaluation of the experiences and opinions of 17 undergraduate and postgraduate students at the University. The findings show that dementia education increases knowledge and confidence and is a positive driver for change and improvement but the cultures of care within many dementia care settings can hamper the implementation of theory.' (Social Care Institute for Excellence, written submission)

'It also means that we need to be person-centred towards our staff and look at their well-being. They do not go home to a person-centred home.'

Where are they going to get their person-centredness from? Because it actually takes a lot to be with somebody, particularly at a repetitive stage or a part of their journey.’ (Wyllie, 18 March, oral evidence)

Variable quality of care service managers

57. Furthermore, a lack of managers with good generic leadership skills in some organisations is identified as a barrier to workforce development. Alzheimer’s Society’s submission cites evidence suggesting that skills learnt during training are more likely to be sustained if training is followed by a formal management programme. They argue ‘regular staff supervision alongside positive reinforcement of good practice is necessary to sustain good practice learnt during training.’ CSCI’s See me, not just the dementia report found that vacant manager posts seemed to be one reason that training was not implemented and the homes were performing poorly.¹⁶ Buz Loveday, Dementia Care Trainer, also describes the negative impact of poor managers:

‘Poor management and leadership skills are also a vital barrier to good dementia care and improvement of skills. Many staff who attend training courses I run report that their managers neither support them in their efforts with people with dementia, nor have any knowledge themselves regarding person-centred care. Managers are frequently punitive rather than encouraging, fail to appreciate the vital role that staff play in the ongoing assessment of people with dementia and their changing needs, fail to lead a process of good communication and co-operation within teams, and prioritise the efficient running of the care service (eg through rigid routines) above the flexibility necessary to address individual needs.’

Local authority commissioning practices that do not support good care

58. Poor commissioning by local authorities that may not understand dementia can also create barriers to good care. Commissioning task-oriented home care visits of 15-minute durations was frequently cited as running counter to everything that is known about good dementia care. Witnesses also cited as a fundamental problem, the failure to incorporate sufficient time for care staff to travel between assignments.

‘Training is worthless unless you give the staff the time to do their job properly.’ (Tonnison, 17 March, oral evidence)

¹⁶ Commission for Social Care Inspection See me, not just the dementia, 2008

‘They are mostly in a rush. But sometimes this is not their fault as they are double-booked with patients miles apart. Hence they have to make it up by pinching time from each patient... We have up to six or more different ladies in a week. Hence, no one is responsible and care can be hit and miss.’ (Anonymous)

‘I was so impressed with what Helen was saying about the different activities that people can get involved in and that is of course what we have not been able to do in domiciliary care because it has been totally task-oriented. No one would have had permission to do any of those things. You just had to do the tasks which were prescribed for you and get out as quickly as possible. It has been frankly soul-destroying.’ (Sawyer, 18 March, oral evidence)

‘There have been occasions when staff ‘readiness and willingness’ to offer personalised care has been restricted. For instance, when working with service users referred by the local authority who commission care time in blocks of unrealistic time frames (15 minutes) with a requirement to complete a ‘task ‘. This time specification is perhaps appropriate when staff need to carry out easily managed physical care tasks for a service user or where the person requires, for example, a hot meal prepared using a microwave. Where the intervention is for a person with dementia, with all that that entails, domiciliary care workers commissioned in this way are unable to achieve outcomes for the person with dementia or spend valuable time building a relationship and delivering personalised care.’ (Guideposts Trust, written submission)

Conclusion

59. **There is clear evidence that the values and ethos of an organisation can be major barriers to workforce development. Management staff without good leadership skills or dementia care knowledge stand in the way of staff development. Commissioning practices can also create barriers because of the working practices they create. In particular, what appears to be a systemic failure by a number of local authorities and/or their private sector partners to give adequate travel and preparation time to their staff in completing visit assignments to individuals with dementia gravely undercuts the personal development of care staff. The evidence is clear that training will not lead to workforce development if organisational barriers mean new knowledge can not be implemented and built upon.**

Funding problems

60. Association of Directors of Adult Social Services (ADASS) is one of a significant number of witnesses who identify lack of funding for dementia training as a barrier to improvement. Service providers talked about the very slim margins they were working with, which made it very difficult to provide the level of training that the workforce required. Alzheimer's Society discussed how they had to top up what they earned from commissioners in order to provide training, but many independent sector services cannot do this. Witnesses highlight that it is not just a matter of paying for training, but also paying for staff to cover those who were attending training sessions.
- 'I know that the Alzheimer's Society day care costs about £20 an hour. We fundraise to top up what we can earn from a commissioner, but our competitors are being awarded commissions at £13 an hour. I know the difference between £13 and £20 and a lot of it is training. We get excellent reports in our CSCI, our competitors get average and below and nothing happens.' (Sutherland, 17 March, oral evidence)
61. Concern was expressed by UKHCA that funding made available to local authorities to train the social care workforce is not passed on to independent sector organisations. They explain that, 'Despite delivering nearly 80% of homecare, a national grant to local authorities to distribute across the entire social care workforce was in the main (63%) spent on local authority staff in 2006–7 and there was a £26 million under-spend.'
62. However, Steve Milton and Buckingham County Council highlight the fact that private sector providers do not always avail themselves of free training. The reasons behind this must be explored. It may be that they do not perceive dementia training as a priority, or that it is too expensive to pay for replacement care for staff attending training.
63. Submissions explain that budget restrictions within social services not only limit purchasing of training but also hamper the provision of good care in other ways, for example, the short time allowed for domiciliary care visits (Guideposts Trust) and low ratio of staff to clients (Buz Loveday, Dementia Care Trainer). Home care providers also express disappointment that funding levels do not allow for the work shadowing that is so essential for improving the skills and confidence of care workers. These quotes from Vivienne Geddes (carer for her mother and recently retired owner/care manager of a domiciliary care company) and Simon Williams (ADASS), illustrate how budgetary constraints can stifle good quality care.

‘Marrying this increased demand and decreased funding is at odds with the concept of person-centred care from skilled, vetted, well-trained, well-managed staff (who are in short supply as they are seriously underpaid for what they do). Impossible. The support that can be offered to Service Users in the community in two short visits a day, to assist with practical things like personal care, medication and nutrition is woefully inadequate for dementia sufferers bewildered even in their own environment. Add to that, “choice, respect, dignity etc” and even the most highly skilled mental health care workers are unable to achieve this minimum: encouraging a person to take her tablets or change her clothes when her “choice” is otherwise takes time and trust.’ (Vivienne Geddes, written submission)

‘Increasingly, councils through their directors of social care, have been seeking to stretch the money further and further and in a lot of places that has been through trying to screw down the hourly rate; it has been through prescribing ever more precisely what it is that we think people should have and, frankly, I think there is recognition that there are diminishing returns and here it is becoming self-defeating. It is certainly having an impact on quality and I am not even sure it has actually been helpful in managing our budgets. In fairness to our social workers and colleagues, let’s remember that this is against a backdrop of intense pressure on funding.’ (Williams, 18 March, oral evidence)

Failure to commission for quality

64. There is also criticism of local authority commissioners who continue to commission poor quality services and do not reward providers of good quality services. There is a sense that, in many areas, cost is more of a concern than securing good outcomes for people with dementia. This creates little incentive for services to develop their workforce.

‘I was in Croydon the other day and we had 32 different providers for their domiciliary care and you cannot tell me that that is because they have chosen quality services. They have chosen services where actually at the end of the day – I am not going to say what the conversation was about – someone does not sleep happily about because they know that for some of those services the staff are not trained and not trained going into people’s houses or offering care. Some of it could be a very clear steer to commissioners about the quality of dementia care services that they commission.’ (Parsons, 17 March, oral evidence)

‘Worcester County Council who commission services from us and with whom we have a contract have acknowledged the training we have done and have actually asked us to mentor their staff. Are they willing to pay

more for that service? I am sorry to bring it back to funding because that argument is well-versed but, no, they cannot. We are a not for profit organisation but we are not for loss either. We do invest in our staff and the quality is in our quality ratings from CSCI, whatever people think about those. I have got nine three star homes. I believe in promoting quality and looking at it from the residents' perspective, but it has not changed the finance that is available to us.' (Blackburn, 18 March, oral evidence)

65. However, there are also good examples of councils who look to ensure people with dementia receive good services by rewarding good providers. For example, Kirklees Adults and Communities Directorate have introduced a Quality Scheme for care homes: 'Upon meeting dementia quality standards, homes are paid a premium payment per council funded placement.' They explained that many dementia homes are now working towards these standards.

Conclusion

66. **The evidence demonstrates the general consensus that budgetary constraints have hampered the development of the workforce. Pressure on budgets also risks the creation of working practices that inhibit good care. Commissioning processes hamper workforce development if they do not reward organisations that develop their staff.**

Support from external organisations

67. Dementia is a complex medical condition – the UKHCA writes of the social care workforce being required to accept 'quasi-medical' roles; support and training from local health specialists can help to develop the dementia care skills of social care workers. Yet submissions indicate poor links between social care and health colleagues:

'In some areas, there is a distinct lack of support and involvement from health colleagues. People with dementia being supported at home or in care homes have much higher levels of complex needs now, but the level of advice and specialist support from GPs, District Nurses and Community Psychiatric Nurses can be very limited. There has been a sense that dementia is a social care issue, and the recently launched strategy must change this, making it clear that it is a complex illness requiring significant health service support. Working alongside health colleagues and having access to their specialist knowledge could help raise skills levels amongst social care staff.' (SCIE, written submission)

‘I think it is about training staff within the care home to recognise when they need to bring in external services and I think that is where one of the major problems is, this gap between the external community, the professional community, the social community as a whole and the care home. Care home residents tend to be out of sight and out of mind and often I think that the staff within the care home do not want to involve external services.’ (Dalley, 17 March, oral evidence)

68. This reflects the findings of the previous APPG inquiry into the prescribing of antipsychotic drugs. This report recommended that care homes must receive effective support from external services, including GPs, community psychiatric nurses, psychologists and psychiatrists.

Conclusion

69. **Dementia is a complex medical condition and specialist services have an important role to play in the care of people with dementia, in all care settings. We support the National Dementia Strategy encouragement of links between specialist services and care homes to support workforce development. Domiciliary care staff would also benefit from such links. In particular, it is essential that much closer joint working between social services and healthcare professionals takes place – not least in linking with families and friends of people with dementia.**

Aspects of the current regulatory system

70. In addition to standards around dementia care training, a regulatory system that supports good care practice would help prevent the organisational barriers discussed in paragraphs 54 – 56. There was discussion about whether the current regulatory system supports the development of the workforce.
71. There has certainly been improvement against National Minimum Standards. However, many witnesses point out that these were of course ‘minimum’ standards that have been in place since 2001 and yet many services still do not reach them. It is also noted by witnesses and confirmed by CSCI that these standards are due to be reviewed.
72. Some witnesses were very concerned about the failure of CSCI to take action against poor services – in particular, homes that failed to meet even the minimum standards.

‘Sometimes with the CSCI requirements – and I have looked at reports because I have audited them – they come out time and time again that they do not actually say, “Right, that is it; we are not going to register you”

or “We are going to suspend your admission.” So they do not actually come down strongly and there are no sanctions at the end of the day.’ (Parsons, 17 March, oral evidence)

‘The management of medication, still about half of all care homes fail to meet the national minimum standard for the management of medication in care homes. We may want to aspire to higher standards but at least we ought to be meeting minimum standards and I do not think that that is a lesson that CSCI has ever been willing to learn, and I just hope – all fingers and toes crossed – that CQC will start to think a little differently.’ (Dalley, 17 March, oral evidence)

73. In contrast, service providers feel CSCI have always followed up non-compliance of standards in their services. Sheena Wyllie, Barchester Healthcare, suggested that in her case it was because Barchester is a big organisation with high standards expected of it.

Conclusion

74. **The evidence raises the question of whether the inspection process, rather than having a standard approach to improvement, works well at promoting excellence in good services but does not support improvements in poorer services or address the issue of coasting in other services. It is important that the review of minimum standards takes full account of lessons learnt during the period that the current minimum standards have been in place.**

3. Solutions to delivering system-wide workforce change in dementia skills

Dementia care workers need the right human qualities and must also be trained in dementia care

75. Witnesses identify that getting the workforce right starts with recruiting people who have the right human qualities. Brenda Walker (Dementia Care Trainer) quotes Geraldine Sharpe of Cherry Trees, Nottingham, whose approach to interviewing is, 'I recruit kindness, I can train everything else!' Brenda explains, 'She has an excellent workforce including several staff who would not normally have got through the interview process – and she keeps them.'
76. Sharon Blackburn also highlights the importance of recruiting the right people:

'It actually starts at recruitment as well because obviously you want somebody to be competent in terms of the actual care, so they need to know how to wash/bathe and assist people with everyday activities of living, but the softer element is have they got people skills? Can they engage with people? How can they relate and think about how they themselves would like to be treated and then convey that and if it is not acceptable to themselves why is it acceptable to somebody else who actually now may not be in a position to communicate in the way that they used to?' (Blackburn, 18 March, oral evidence)

Dementia training should be mandatory for care staff working with people with dementia in all care settings

77. As Professor June Andrews of Stirling University points out, this is not to say that having the right human qualities is enough – it is a first step. She writes that, 'implying that a kindly person using common sense will instinctively know what they ought to do for a person with dementia in any given circumstance because there is not much that can be done' is used as a reason for failing to train the home care and care home workforce.

78. ADASS is one of many witnesses including carers and people with dementia, Alzheimer's Society, SCIE and professional organisations who express the view that providing training is necessary to deliver workforce change in dementia skills. Many witnesses state that dementia care training must be mandatory for social care staff in the care home and domiciliary sectors and there must be clear guidance on the level of training that must be provided and the outcomes for people with dementia that should result from training.

'There need to be clear and specific mandatory guidelines about the minimum level and type of training that is required, and inspection must focus on the effectiveness of this training in terms of its outcomes on staff attitudes and approaches and quality of care.' (Buz Loveday, Dementia Trainer, written submission)

'In order to ensure an appropriately trained workforce, the national workforce and training organisations must work together to ensure that dementia training is included as part of any national core training programmes for health and social care staff. Clear training pathways need to be established that are incentivised by minimum requirements and lead to appropriate skills for roles performed. These need to be broad enough to encompass the wide range of roles within the sector and not just add a higher education element at the advanced end. The introduction of recognised qualifications for care staff working with people with dementia would improve the skill base and status of this work and support the development of career structures.' (ADASS, written submission)

'Given the numbers of people living in care homes not specifically registered for dementia care, and the projected increase in cases of dementia in future, it is recommended that all health and social care staff, irrespective of setting and registration category, receive a basic level of dementia awareness training.' (SCIE, written submission)

79. A number of witnesses support the 'dementia champions' training model, which was recommended in the National Dementia Strategy for England. As CSCI explains, 'each service has a lead person working on developing the service and ensuring that staff have the right ethos and training in terms of dementia care. Dementia care champions can also develop local networks to share best practice and encourage other services to adopt the initiative.'
80. It was acknowledged that training should focus on areas that have been identified as particularly in need of improvement or which care staff may find especially demanding, for example communication, supporting engagement and responding to behaviour that is challenging. Furthermore,

it needs to encompass the needs of different groups of people with dementia, including younger people with dementia. Training must also help staff understand the different forms of dementia and the different impact they have on individuals.

Conclusion

81. **The Group notes the importance of qualities including empathy and warmth for dementia care staff and believes these skills are not sufficiently valued or rewarded within the workforce which, in part, has led to the inappropriately low status of dementia care workers.**
82. **We conclude that the dementia care workforce is unlikely to develop the skills and attitudes necessary to provide excellent care to people with dementia without substantial programmes of training. Different groups of staff are likely to require different levels of training, depending on the needs of the people they work with. However, given the high prevalence of dementia amongst recipients of social care, all staff need a minimum of dementia awareness training.**
83. **The Group supports the statements that training must focus on areas of particular need. Training and development programmes must also take into account the particular characteristics of the workforce. We also note that the National Dementia Strategy for England states that ‘the need for improved training is a priority that runs across all the themes in the Strategy’ and therefore urge progress in this area of work.**

The regulation system must be developed in a way that promotes the development of the dementia care workforce

84. There was discussion about social care regulators getting the balance right between inspecting against ‘inputs’ such as training, and outcomes, such as the quality of life of people with dementia. Witnesses applauded the use of Short Observational Framework for Inspection (SOFI) to assess the outcomes of care for care home residents with dementia. Alzheimer’s Society point out its usefulness in developing the workforce: ‘Observation of staff practice helps to paint a picture of areas of strengths and weaknesses, which should inform individual and team development plans.’ However, it is generally agreed that there must also be some focus on inputs required to achieve those outcomes. For example, Dr Gillian Dalley, Residents and Relatives Association, says:

‘At least the regulator is removed from the pressure of budgets in that direct sense and I think that to simply say that the regulator is only

concerned with the product, the output, is too optimistic. We see care providers themselves saying, “Yes, we can get by and produce wonderful happy residents with the minimum of outlay on training or good quality environment, whatever; look at my lovely, happy residents, they are all smiling and very contented.” But I think the regulator has to be concerned about the inputs as well and to be able to lay down some standards about training – accredited training, for example. That would actually address some of the worries about churn because poaching is less likely to take place if everybody has to be trained or at least a programme of training across the sector over a period of years is put in place. That is one of the ways of addressing some of those disparities and anomalies.’ (Dalley, 17 March, oral evidence)

85. David Walden, CSCI, discusses the regulator’s role in assessing outcomes, but also in understanding what inputs are necessary:

‘We have been trying to look at it from the other angle which is, “what does it feel like to be in this service with this condition and what sort of experiences do people have? Then, to a degree, working back up the line as to what the inputs might need to be to make that better.” There is a tension here because the minimum standards are very input focused now and we have tried to look more at outcomes than inputs. I think the new standards give a further opportunity to push that further towards an outcomes basis.’ (Walden, 18 March, oral evidence)

86. There was also discussion about whether specific dementia standards are appropriate. As stated in paragraph 43 David Walden questioned whether it would be helpful to increase the specificity of minimum standards when they are next reviewed. The evidence presented in paragraph 43 demonstrates that many witnesses feel specific standards should be developed. Also, witnesses pointed to the high prevalence of dementia among older people using social care services (see SCIE at paragraph 78). UKHCA states that: ‘The increasing prevalence of dementia means that the majority of homecare providers will be in the position of offering daily assistance with care and support to people with dementia.’

Conclusion

87. **Outcomes of care in terms of quality of life of people with dementia should be the key concern of regulatory systems. However, because of the evidence relating to the necessity of training for dementia care staff, the Group is inclined to agree that there must be some focus on the inputs.**

88. **Furthermore, we consider that the data demonstrating the high prevalence of dementia among users of social care services predicates the need for some specificity of regulatory requirements relating to dementia. The review of the minimum standards provides an opportunity to address these issues and we note the National Dementia Strategy for England recommends the review should be informed by new dementia core competencies in occupational training.**

Organisational values and principles must be rooted in good dementia care

89. It is emphasised that training will only help promote the well-being of people with dementia if the organisation has the correct ethos and principles of person-centred care. Amanda Thompsell, consultant old age psychiatrist, explains in her written evidence that: ‘Training should be integrated and embedded within an overall philosophy of care from which aims, objectives and procedures are derived.’
90. Knowledge of good dementia care must permeate the whole organisation to prevent barriers being placed in the way of care staff implementing what they learn. Witnesses argue that only when managers understand good dementia care can they provide the guidance, positive reinforcement and working conditions that facilitate good care.

‘You cannot effect a lot of change unless it is out there as a set of principles, as a vision about the person centred care because everything comes from that direction; and if senior management and managers and down in the hierarchy are facing that direction and some really clear direction about what is good quality, and if they have their own quality assurance processes, then there is a better chance that that learning and training will be embedded, and certainly that is a really important part of it.’ (Parsons, 17 March, oral evidence)

Workforce development requires skilled leadership

91. So it is important that managers know about good dementia care but, as identified in paragraph 57, good generic leadership skills are crucial for workforce development. Simon Williams, ADASS, states that good leaders must be prized and supported:

‘The third area is something that is about leadership and culture. We have heard this afternoon some really good examples of where leadership makes a difference. I think as commissioners what we could be doing more of is to actually support those excellent care home managers, those excellent

domiciliary care managers and owners who are actually giving that level of leadership to their staff and that is going beyond sheep-dipping staff and saying yes, you have all been through training and saying no, we actually stay with our staff and support them and actually encourage the right attitudes.’ (Williams, 18 March, oral evidence)

92. The Group welcomes the new Adult Social Care Workforce Strategy commitment to attract high calibre graduates and executives of the future to social care. These efforts should run alongside work to encourage the retention and development of good leaders already within social care.

Training in dementia care must extend beyond direct care providers

93. Beyond the training needs of managers, witnesses also point to the need to train a range of other personnel, including local authority staff. These staff need to understand what good dementia care looks like if they are to develop systems that support good outcomes for people with dementia. Maria Parsons explains the benefits of multi-disciplinary training:

‘If we just train front line staff we are never going to change anything. We have to target the managers so that the managers manage better. Many of them do not usually understand dementia very well and they certainly do not understand leadership issues very well, although there is a lot of training that goes on in individual homes because they have to tick the boxes because of CSCI. I do a lot of training for authorities where I do multi-disciplinary training where I will have all sort of people like financial people, homecare staff, reviewing officers, social workers, commissioners, all sorts of people all in the same room, homecare staff, managers and front line staff, and that is a very, very good way of developing a cross-culture of understanding of what dementia is all about and how their different roles will impact on one another.’ (Parsons, 17 March, oral evidence)

Conclusion

94. **There is clear evidence that training staff is only one part of the solution and it is only effective if the culture of service providers and commissioners supports good care. The development of the workforce requires a range of personnel to understand how good dementia care is delivered. Effective managers are vital to inspire and lead care staff.**

Dementia trainers must be of consistently good quality

95. As discussed in paragraphs 51–52 there are concerns around the variable quality of dementia care trainers. Witnesses highlight that an accreditation system for dementia care trainers would provide much needed quality assurance:

‘If there was greater power with inspectors and commissioners to actually insist on what good quality care training looked like, my job would be a lot easier. Crucially, the life of people with dementia would be improved immeasurably.’ (Milton, 17 March, oral evidence)

‘Currently the Alzheimer’s Society has an accredited system but that is actually being reviewed at the moment because there are concerns that the level of quality assurance is not as detailed as it should be; but in order to get to be an Alzheimer’s Society trainer you do have to go through quite a rigorous and people will watch you training. That is the ongoing quality system that we are talking about.’ (Sally Knocker, 17 March, oral evidence)

Standardised training packages would provide quality assurance and consistency

96. Many of the concerns around the quality of trainers centre on the provision of training courses of insufficient depth and quality to make a difference to care. The lack of agreed standards on levels of training or a nationally recognised dementia-specific qualification means there is insufficient guidance.
97. Alzheimer’s Society argues that ‘standardised kitemarked training will help to remove inconsistencies in the quality of training programmes.’ This is also recommended in the National Dementia Strategy for England because it will assist commissioners and care providers in selecting effective training. Furthermore, Steve Milton pointed out that kitemarking training would make it easier to convince providers to purchase more realistic levels of training.
98. The development of the new Qualifications and Credit Framework Skills for Care which will reform the current set of National Vocational Qualifications (NVQs) and Vocationally Related Qualifications (VRQs) provides an opportunity to develop a qualifications pathway specific to dementia. In an explanatory note requested by the Group, Andy Tilden explains how this could work for staff working in dementia services:

‘For dementia services this will mean that workers will undertake a generic core of units common to all adult social care workers (possibly

communication, values, principles of good care practice) as well as a series of dementia specific units designed to support people with dementia. These units will be a combination of performance and knowledge units designed to ensure that workers know how to work with a range of people with dementia but also ‘can’ work with people with dementia.’ (Tilden, explanatory note)

99. It is expected that QCF units and qualifications will underpin apprenticeships from 2010. This presents an opportunity to develop apprenticeships in dementia care.

Conclusion

100. **The Group concludes that the consistency of the quality of training providers must be improved and this requires a robust accreditation system. Alongside this, the development of standardised training programmes could increase the consistency of the content of training programmes. This may help to counter the fragmented and ad hoc arrangements described by Laing and Buisson (Dementia care services UK market briefing, 2009).**
101. **We warmly welcome the development of the new Qualifications and Credit Framework and the opportunities it creates for development of the dementia workforce. It is important that this allows flexibility to respond to individual training needs. The new Framework may also provide an opportunity to develop a career path within dementia care. We welcome the commitment from the Department of Health within the Adult Social Care Workforce Strategy to develop career pathways within social care; the Group would encourage that work to consider career pathways within dementia.**

Funding issues must be addressed

102. Funding problems can be addressed by the development and implementation of a standardised training programme in dementia care because it can be linked to funding streams such as Train to Gain. Phil Willis MP pointed out in oral evidence sessions that there is a billion pounds in the Train to Gain budget, half of which is not being used for the purpose of training. Andy Tilden explains that this funding is not available for much of the dementia care training that goes on currently because it is not part of a standardised training course:

‘The development of the Qualifications and Credit Framework from November will allow us to come up with a series of replacements to the

NVQ which will enable us to have pathways within that, so for example a qualification in dementia pathway, which could then be funded by Train to Gain. Our conversations with the Learning and Skills Council have agreed with our thinking that we simply come up with a replacement, so in the future there will be the opportunity for providers to access funding specifically for a qualification which would highlight dementia or learning disability or mental health in ways that the current system does not. What happens with the current system is that you have a generic qualification and the employer then bolts on or undertakes separate learning which is often not funded.’ (Tilden, 18 March, oral evidence)

103. Alzheimer’s Society argues that developing standardised training could also improve the relationship between service providers and commissioners because it would support ‘the development of a methodology to calculate how much it costs to properly train a workforce. This could be used in fee negotiations between service providers and commissioners.’ Witnesses are clear that better relationships are important:

‘We have really got to get into longer term, more mature relationships with those care providers who we feel are in the business for the right reasons and for the longer term.’ (Williams, 18 March, oral evidence)

‘It needs to be a partnership arrangement. All of these players have a role to play and the problem is that none of them are communicating with each other. The regulator needs to work with the commissioner and needs to work with the individual who the service is for and needs to work with the curricular bodies and with the providers of the training. But all of those actors in that arrangement are all operating in their own little worlds and they are not connecting up. There is money in the system; it is not all about more money, it is about making what we currently have work more effectively together and how we can make that happen.’ (Sutherland, 17 March, oral evidence)

104. A move to commissioning for outcomes was discussed. Helen Joy, Brunelcare, argues that we will be missing a trick if training is provided without looking at the outcomes of a service:

‘We are not paid, nor are we with people who do not have dementia, to actually reduce hospital admissions, reduce falls, reduce admissions to care homes and also to increase carers’ ability to care for them. That would fundamentally change the whole business. We might talk about all this training but if the commissioners do not commission like that, I think we are not doing the most appropriate thing.’ (Joy, 18 March, oral evidence)

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105. Simon Williams, ADASS, stated that while specifying training within a contract is 'a basic must-do', it is equally important for commissioners to establish whether that training is leading to better outcomes for people with dementia.
106. Witnesses are clear that rewarding services that do achieve good outcomes is an important way of encouraging quality dementia services that support workforce development.

Conclusion

- 107. Issues surrounding funding levels act as a barrier to workforce development. We believe the new QCF presents an important opportunity to address these issues, as training can be more easily linked to available funding streams. It is vital that better relationships develop between service providers and commissioners that are based on a proper assessment of what it costs to provide quality dementia care. Training all staff involved in dementia services, including commissioners, in what good dementia care looks like, may help to improve understanding about costs.**

Links with external services

108. Poor links between the NHS and social care providers is identified as a barrier to workforce development. A number of witnesses, including SCIE and UKHCA, speak of the necessity of improving links between the two:

'There has been a sense that dementia is a social care issue, and the recently launched strategy must change this, making it clear that it is a complex illness requiring significant health service support. Working alongside health colleagues and having access to their specialist knowledge could help raise skills levels amongst social care staff.' (SCIE, written submission)

'Importantly, we agree there must be a much greater emphasis on joint working with the NHS. Homecare providers receive very little information from community psychiatric nurses (CPNs), particularly on communication and behavioural needs. It is the CPN who can advise on how to address mental health issues and while a social worker will do an assessment of care needs, these are often functional, and relate to washing, dressing and eating ... If the government is serious about personalising services for those with dementia, it is crucial that communication channels are forged between the NHS and the social care worker at the front line, and a new

structured approach to sharing information about the person with dementia is developed.’ (UKHCA, written submission)

109. This is linked to the failure to commission social care services for the types of outcomes which are likely to be of concern to the NHS, for example reductions in falls. A failure of the two systems to work together leads to missed opportunities for mutual benefit in terms of efficiencies and outcomes for people with dementia.

Personalisation

110. It was generally agreed that much more debate is required on how to overcome the workforce development issues that arise in the ‘personalisation’ agenda. In particular, how to get the balance right between having enough regulation to ensure people’s safety without compromising the level of choice and control. Simon Williams points out that the best way to resolve these issues is to listen to the views of service users and carers:

‘There is a very live debate going on in our association about how much regulation should there be. If we have too little it is essentially an unsafe environment, particularly as personalisation takes off. If we have too much, then it is simply going to deprive the people of the kind of rightful choices that they want to make and we will be accused of being paternalistic. We have to get this right and the only way in which to get this right is to listen really closely to what our service users and carers are telling us.’ (Williams, 18 March, oral evidence)

‘I think that with the safeguards on all sorts of things in relation to adult protection as well – as they actually have the training – there is a lot of safeguarding work that needs to be done and it needs to run alongside the rollout of individualised payments, and on the pace of the roll out there is concern that that work on safeguarding is not running at a commensurate level. But people will be very vulnerable because it is basically privatising the thing and I do not know where the regulation is going to come from those kinds of relationships.’ (Sutherland, 17 March, oral evidence)

Conclusion

111. **The Group believes it is important that individuals living with dementia are able to benefit from the opportunities the personalisation agenda presents. We recognise that some people with dementia may not be concerned about the level of training of staff if they know excellent care**

can be provided. However, other individuals may benefit from safeguards regarding training. The Group agrees that it is vital for people with dementia and carers to be involved in debates around taking forward the personalisation agenda and, in particular, issues around training.

4. Conclusions and recommendations

Conclusions

This evidence suggests the workforce as a whole is not ready to deliver personalised care to people with dementia and their families, although there are examples of excellent practice by skilled and dedicated staff. However, it appears that low levels of knowledge of good dementia care are far too common. There are examples of a basic failure to treat the person with dementia as a fellow individual, with a need for social interaction, respect and warmth (paragraph 22).

Dementia is a complex condition and providing good care requires a high level of skill and empathy. Yet despite this, the evidence shows levels of training are low, even in specialist dementia services, and this is reflected in the lack of knowledge and attitudes of many social care staff. This suggests a misguided belief that specialist training is not required to provide support to people with dementia. The result of this is a vulnerable group in society experiencing nothing like the standard of care they deserve (paragraph 28).

Negative attitudes about dementia and the low value society places on older people and people with cognitive difficulties act as barriers to workforce development. This is exacerbated by slowness to recognise or diagnose dementia which means that, by the time this situation is accepted, the challenges faced by care staff and others will be even greater. Although we know much more now about how to promote quality of life in people living with dementia, this has yet to feed through consistently to the training of staff and care practice (paragraph 34).

The Group concludes that the low status given to people working in dementia care is a barrier to workforce development as it creates low morale and motivation. Although staff may be intrinsically motivated to improve skills and gain qualifications, the lack of a standardised career path with associated salary increases means this incentive is often not available. The high turnover rate is also a disincentive to organisations to invest in workforce training and development (paragraph 39).

It is clear that the low level of training provided to the majority of staff in this skilled area of care makes it difficult for the workforce to provide the right level of support. The lack of regulatory requirements stipulating the level of dementia care training staff must receive is a strong disincentive to any structured development or

even maintenance of standards as well as permitting the provision of inappropriately low levels of training. The situation is not helped by the delay in registration of care workers by the GSCC (paragraph 45).

The Group concludes that the dementia knowledge set may clarify learning outcomes for some organisations, but it is not appropriate for all. Development of a common curriculum should take account of the characteristics of the workforce and should address issues of delivery and engagement with a highly varied workforce – some of whom may need a much stronger social grounding to improve interaction with patients (paragraph 50).

The effectiveness of training relies heavily on the quality of the trainer so it is of concern that there is inconsistency in the quality of training providers. The lack of accreditation or regulation of training providers is without doubt a causative factor behind this inconsistency (paragraph 53).

There is clear evidence that the values and ethos of an organisation can be major barriers to workforce development. Management staff without good leadership skills or dementia care knowledge stand in the way of staff development. Commissioning practices can also create barriers because of the working practices they create. In particular, what appears to be a systemic failure by a number of local authorities and/or their private sector partners to give adequate travel and preparation time to their staff in completing visit assignments to individuals with dementia gravely undercuts the personal development of care staff. The evidence is clear that training will not lead to workforce development if organisational barriers mean new knowledge cannot be implemented and built upon (paragraph 59).

The evidence demonstrates the general consensus that budgetary constraints have hampered the development of the workforce. Pressure on budgets also risks the creation of working practices that inhibit good care. Commissioning processes hamper workforce development if they do not reward organisations that develop their staff (paragraph 66).

Dementia is a complex medical condition and specialist services have an important role to play in the care of people with dementia, in all care settings. We support the National Dementia Strategy's encouragement of links between specialist services and care homes to support workforce development. Domiciliary care staff would also benefit from such links. In particular, it is essential that much closer joint working between social services and healthcare professionals takes place – not least in linking with families and friends of people with dementia (paragraph 69).

The evidence raises the question of whether the inspection process, rather than having a standard approach to improvement, works well at promoting excellence in good services but does not support improvements in poorer services or address the issue of coasting in other services. It is important that the review of minimum

standards takes full account of lessons learnt during the period that the current minimum standards have been in place (paragraph 74).

The Group notes the importance of qualities including empathy and warmth for dementia care staff and believes these skills are not sufficiently valued or rewarded within the workforce, which in part has led to the inappropriately low status of dementia care workers (paragraph 81).

We conclude that the dementia care workforce is unlikely to develop the skills and attitudes necessary to provide excellent care to people with dementia without substantial programmes of training. Different groups of staff are likely to require different levels of training, depending on the needs of the people they work with. However, given the high prevalence of dementia amongst recipients of social care, all staff need a minimum of dementia awareness training (paragraph 82).

The Group supports the statements that training must focus on areas of particular need. Training and development programmes must also take into account the particular characteristics of the workforce. We also note that the National Dementia Strategy for England states that ‘the need for improved training is a priority that runs across all the themes in the Strategy’ and therefore urge progress in this area of work (paragraph 83).

Outcomes of care in terms of quality of life of people with dementia should be the key concern of regulatory systems. However, because of the evidence relating to the necessity of training for dementia care staff, the Group is inclined to agree that there must be some focus on the inputs (paragraph 87).

Furthermore, we consider that the data demonstrating the high prevalence of dementia among users of social care services predicates the need for some specificity of regulatory requirements relating to dementia. The review of the minimum standards provides an opportunity to address these issues and we note the National Dementia Strategy for England recommends the review should be informed by new dementia core competencies in occupational training (paragraph 88).

There is clear evidence that training staff is only one part of the solution and it is only effective if the culture of service providers and commissioners supports good care. The development of the workforce requires a range of personnel to understand how good dementia care is delivered. Effective managers are vital to inspire and lead care staff (paragraph 94).

The Group concludes that the consistency of the quality of training providers must be improved and this requires a robust accreditation system. Alongside this, the development of standardised training programmes could increase the consistency of the content of training programmes. This may help to counter the fragmented

and ad hoc arrangements described by Laing and Buisson (Dementia care market survey, 2009) (paragraph 100).

We warmly welcome the development of the new Qualifications and Credit Framework and the opportunities it creates for development of the dementia workforce. It is important that this allows flexibility to respond to individual training needs. The new Framework may also provide an opportunity to develop a career path within dementia care. We welcome the commitment from the Department of Health within the Adult Social Care Workforce Strategy to develop career pathways within social care; the Group would encourage that work to consider career pathways within dementia (paragraph 101).

Issues surrounding funding levels act as a barrier to workforce development. We believe the new QCF presents an important opportunity to address these issues as training can be more easily linked to available funding streams. It is vital that better relationships develop between service providers and commissioners that are based on a proper assessment of what it costs to provide quality dementia care. Training all staff involved in dementia services, including commissioners, in what good dementia care looks like, may help to improve understanding about costs (paragraph 107).

The Group believes it is important that individuals living with dementia are able to benefit from the opportunities the personalisation agenda presents. We recognise that some people with dementia may not be concerned about the level of training of staff if they know excellent care can be provided. However, other individuals may benefit from safeguards regarding training. The Group agrees that it is vital for people with dementia and carers to be involved in debates around taking forward the personalisation agenda and, in particular, issues around training (paragraph 111).

Recommendations

1. The Group urges the Department of Health to prioritise early work on achieving Objective 13 of the National Dementia Strategy for England – ‘An informed and effective workforce for people with dementia.’
 - Specifically, we recommend they lay out a clear timetable for the development of core competencies and lead this work. These will underpin workforce development.
2. We need to move towards a situation where the workforce as a whole demonstrates effective knowledge and skills in caring for people with dementia.
 - This requires that social care staff working with older people have dementia care training that is consistent with their role.

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- Relevant organisations need to work together to explore how to make this training mandatory, while avoiding dementia care training becoming a tick box exercise.
 - The inspection process will be a key part of understanding whether the dementia care workforce has the required skills. We recommend all staff involved in the inspection of services for people with dementia are trained in and encouraged to use the Short Observational Framework for Inspection (SOFI) tool.
 - The revision of the National Minimum Standards must consider whether dementia specific standards could promote better outcomes.
3. It is important that workforce development programmes are carefully designed to meet the needs of care staff and ultimately improve the lives of people with dementia.
- Training must not be a one-off event but incorporated into an ongoing training and development programme. This should encourage a learning culture within an organisation that promotes reflective practice.
 - Training programmes must take into account the characteristics of the workforce, for example the number of care staff with a first language other than English and potentially low interest in academic training.
 - Innovative approaches to training home care workers should be explored that take into account the isolated nature of the work, for example work shadowing in care homes.
 - Training in dementia care must also be provided for leaders to ensure they create working practices that promote good care and can provide appropriate guidance and positive reinforcement to their staff.
4. There must be greater regulation of dementia care trainers to combat the current inconsistencies in quality. We recommend the development of a kitemarking system.
5. There must be greater recognition of the level of skill required to provide good quality dementia care as well as the importance of maximising the quality of life of individuals who develop dementia. This entails:
- Providing terms and conditions of employment that not only attract and retain quality staff, but reward them appropriately for carrying out this valuable and skilled work.
 - Creating organisations with principles and working practices that enable staff to carry out good person-centred care.
 - Consideration of how the new Qualification and Credit Framework could be used to develop a career pathway within dementia care.

- Acting to prevent any further delay on the registration of care workers by the GSCC.
6. It is vital to develop effective working relationships between commissioners and service providers that are based on a good knowledge of what good dementia care is and what is required to provide it.
- Providing commissioners with an appropriate level of training in dementia care could facilitate this.
 - Contract negotiations should be based on a shared understanding of what good care costs and must incorporate the cost of creating and supporting a skilled workforce.
 - Funding decisions must incorporate the potential extra costs of workforce development in the home care sector, for example the additional costs of work-shadowing and bringing home care staff together.
 - Commissioners should reward service providers who achieve good outcomes for people with dementia.
7. Good dementia care is reliant on well-integrated working between social care and healthcare. This must be improved:
- Care homes and home care providers must receive effective support from specialist mental health teams, who can help meet the training needs of care staff and managers.
 - Integration of the two systems should be supported by practices such as commissioning social care services to produce outcomes of concern to the NHS, such as falls reduction.

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