

INTRODUCTION

Dementia is an international health priority, with nearly 800,000 people diagnosed with dementia in the UK alone (Alzheimer's Society, 2010). Worldwide this figure is estimated to be at 35.6 million, 2010 figures, with a predicted rise every 20 years of double this figure, to an estimated 115.4 million in 2050 (World Health Organisation [WHO], 2012). Although recent figures suggest that these original estimates are in fact lower than expected (Matthews et al., 2013), dementia remains a substantial public health issue and one which requires specialist care and support (WHO, 2012).

The term dementia covers a number of different symptoms, which are related to, but not exclusively, a loss of memory, ability to reason, change in personality and loss of communication skills (National Institute for Health and Clinical Excellence [NICE], 2006; Alzheimer's Society, 2009b). The World Health Organisation (WHO) (2012) describe dementia as a progressive syndrome, requiring complex care and specialist services (NICE, 2006). With approximately 1:6 people over the age of 80 and 1:14 over the age of 65 with a type of dementia in the UK (Alzheimer's Society, 2009b), the need for a skilled workforce to provide quality care and services for people with dementia (PwD) is paramount (National Health Service [NHS], 2010).

Person-centred care is considered to "underpin good practice in the field of dementia care" (NICE, 2006, p.6), with its focus on valuing personhood, individualisation of care, developing care from the perspective of the PwD and developing caring relationships. This is equally true when considering the carer and ensuring their needs are also encapsulated, enabling them to enhance the care and support they offer to their cared for person. Bridges' et al. (2009) study with PwD adds weight to the person-centred approach with patients reporting

that they wanted staff to learn about them, as an individual, and to “see who I am” (Bridges et al., 2009, p.3). To ensure this approach is adopted across health professionals, the provision of adequate training has been identified as a key priority (WHO, 2012, NICE, 2006, Moyle et al., 2008, DOH, 2009). NICE (2006, p.11) state that “access” to skills development training in dementia should be made available to staff working with older people. Identified subject matter for inclusion in training is: early diagnosis and recognition of symptoms of dementia; understanding of the different types of dementia; pharmacological treatments; application of the principles of person-centred care; development of communication skills and understanding ethical issues and principles (NICE, 2006, WHO, 2012). In more general terms, the development of knowledge and skills in this field is imperative to improving dementia care, with the WHO (2012, p.4) identifying there being “an urgent need to improve the awareness and understanding of dementia”.

A gap in dementia care education has been identified (WHO, 2012), with health professionals acknowledging their lack of adequate knowledge and skills in this area. An All-Party Parliamentary Group on Dementia (2009) identified that the number of staff receiving dementia training remained low, even amongst specialist providers, with approximately a third of specialist dementia care home providers reporting to have no dedicated training on dementia for their staff. The recommendations made in this report highlight the need for the health “workforce as a whole” (2009, p.42) to develop their skills and knowledge in the care of PwD and that training should be aimed at improving the lives of PwD. The Alzheimer’s Society (2009b) emphasise the need for awareness of dementia to focus on health professionals “across the health and care sector [to] improve all aspects of a person’s journey through dementia” (2009b, p.26). In their report on the care of PwD on hospital wards, the Alzheimer’s Society (2009a) discuss the role nurses

have in improving care and developing person-centred approaches and identify the need for training as “vital”.

This study presents the findings from an evaluation of a local dementia awareness training programme, undertaken in the East Midlands, UK. The training was designed to up-skill and develop the knowledge of health professionals on dementia, with the aim for those attending the training becoming dementia champions and improving working practices for the care of PwD.

While the study is based on the findings of this local pilot, the implications are potentially far reaching and have a bearing on dementia training for health professionals across the UK and internationally.

METHODS

A mixed methods design was adopted, drawing on the views of stakeholders, workshop trainers and practitioners attending the workshops.

Face-to-face semi-structured interviews were undertaken with stakeholders (n=5) from local National Health Service (NHS) Trusts, with a responsibility for staff development. A discussion guide was designed to obtain qualitative information to explore the views on: the type of training required, preferred delivery methods (length and content), potential improvements and alternative delivery methods to inform future delivery. Interviews included discussions on gaps in existing training provision for dementia awareness within their organisation and the time/financial costs of releasing staff to attend training. Face-to-face interviews were also undertaken with the trainers (n=2), who were from the University of Northampton and one of the locality NHS Trusts, who developed and delivered

the workshops. Themes explored in these interviews ran in parallel with the stakeholder interviews.

A post training questionnaire, comprising open ended questions and one closed question, had been developed by the workshop trainers and it was decided by the commissioners that the evaluation would be best placed to utilise the existing form. The post training questionnaires were completed, anonymously, at the end of each workshop by attending practitioners (n=74). The evaluation team were given access to these questionnaires, enabling use of the data collected to inform the findings of this evaluation. Practitioners were asked to feedback on the usefulness of the training, rate their satisfaction and identify aspects which would be taken into practice.

Appropriate ethical approval was sought by the relevant University School's ethical committee and appropriate informed consent obtained from participants.

A qualitative thematic approach was employed in order to represent the findings of each method of data collection. Interview recordings were transcribed verbatim and Braun and Clarke's (2006) six step thematic analysis framework was adopted on both the transcribed interview data and open ended questions from the questionnaires. Responses from the closed question were entered into the Statistical Package for Social Sciences (SPSS) for descriptive analysis.

RESULTS

Key themes emerging centred on the way the workshops were developed, the range of health professionals who attended the training, learning points from the training, the role of dementia champions and implications for future considerations for dementia training for health professionals.

Workshop development

The development of the dementia awareness workshops, evaluated in this paper, were the result of funding provision from transformational money made available under a Learning Beyond Registration contract with the regional Strategic Health Authority. The training was developed out of a need to provide “*something different*” and fill the gap in current training provided within the locality. A gap analysis of dementia training had been undertaken by the workshop leads to determine what training was available and where the gaps in provision lay. This gap analysis led to the development of the workshop content and identified a need to provide training for community and district nurses, whom it was recognized had a lack of training provision and access to training in dementia within this locality. Key NHS stakeholders within the locality Trusts agreed to the content developed.

The focus of the workshops was to develop an understanding of dementia from the perspective of the carer, PwD and staff working with dementia patients and to develop dementia champions to take the learning back into practice. The training made a deliberate move away from the “typology” and “medical” model to one that was a socio-psychological model and followed Kitwood’s (1997) person-centred approach. Course content focused on the presentation of dementia in a clinical situation, ways in which to identify the difference between dementia, delirium and depression, identified the behavioural and psychological symptoms of dementia and how to respond to these symptoms using coping strategies. In addition, the personal experiences of the PwD were explored through scenarios and discussions were held to explore carer and staff perspectives and experiences with working with PwD.

Six one-day workshops (7hrs) were delivered across the locality, 74 health practitioners attended one of these sessions. The workshops were advertised to staff via each locality Trust and staff self-elected to attend a workshop.

Attendance and audience

The workshops had been designed primarily for district and community nurses, however, a range of staff elected to attend. Job roles ranged from that of clinical psychologists to healthcare assistants. Table 1 presents the full range and number of health professionals who completed the training. *Where no details were provided on professional role, the evaluation team confirmed with the workshop facilitators whether community nurses had attended. The facilitators, to their knowledge, confirmed that these roles were not district or community nurses. Stakeholders acknowledged the lack of attendance by the community nurses, reporting that a lack of time, heavy workloads at the time of the training, or perceived lack of understanding for the need to up-skill in dementia as key reasons for non-attendance by district and community nurses.

"... some of it might have been that, 'Oh, is this relevant?' and of course it is. But I think at the moment... their workload is phenomenal.."

It was also suggested this training might not have been seen as relevant to district nurses' everyday roles, as their focus is often on acute conditions and the treatment of specific conditions. It was suggested, by a couple of stakeholders that their focus is on physical aspects more so than mental.

"But when you start talking about dementia, they are not going in to see someone because they've got dementia, that's the secondary issue for them."

However, stakeholders recognised there was a need for district and community nurses to attend training in dementia so as to develop their skills and knowledge and better support PwD. Ways in which to boost attendance from this group were suggested through improved marketing outlining the benefits to their role and the patient and integrating dementia issues into physical training sessions .

"I mean when they're coming in for training courses on... physical aspects then I think it's opportunism, ... i.e. you're going in and you're giving instructions on what the person needs to do and they've forgotten by the time you've left... and therefore the ulcers are getting worse rather than better ... That's the angle that I would do."

Finally, stakeholders acknowledged that pressures to attend mandatory training would have impacted on the availability of this group to attend external, non-mandatory training, adding that heavy workloads have also meant that "*quite harsh decisions*" have had to be made resulting in attending this mandatory training only.

Despite the unexpected mix of health professionals attending the training – with one facilitator stating: "*we had some people that work a lot more directly with people with dementia than we expected ... and quite a mixture of different disciplines actually*" - the result was positive, with practitioners enjoying lively discussions and gaining an understanding of other staff's experiences of working with PwD. This mix of staff engagement was also cited as a key benefit of the training by the health professionals, as one participant reported the "*discussions about experiences between different professions*" had been the most enjoyed aspect of the day.

Table 1: Participant occupations

| Job role | No |
|--|-----------|
| Clinical Psychologist | 1 |
| Clinical Studies Officer for Mental Health | 1 |
| Clinical Team Leader | 2 |
| Community Teams for People with Learning Disabilities staff member | 1 |
| Community Nurse | 3 |
| Healthcare Assistant | 2 |
| Junior Sister | 1 |
| Nutrition Team staff member | 1 |
| Occupational Therapist | 6 |
| Oncology Medical Physics staff member | 1 |
| Outpatient treatment staff | 1 |
| Physiotherapy | 2 |
| Pre-Op Nurse | 2 |
| Recovery Practitioner | 1 |
| Registered Nurse | 1 |
| Senior Nurse | 1 |
| Senior Sister | 1 |
| Senior Staff Nurse | 1 |
| Sister | 2 |
| Staff Nurse | 18 |
| Stop Smoking Advisor | 1 |
| Student | 1 |
| Trauma Nurse Practitioner | 1 |
| Not stated | 22* |

Attendance for the first of the six workshops was low (Session 1 n=5, Session 2 n=16, Session 3 n=13, Session 4 n=17, Session 5 n=12, Session 6 n=12), however, the numbers improved for the successive sessions, with 12 - 17 health professionals attending each day workshop. Attendance at the workshops was thought to be affected by the capacity to release staff to attend training and by staff's heavy workloads. The release of staff was a consistent theme identified in stakeholder interviews, with the questions of providing cover or having staff absent for a day difficult issues to resolve. One stakeholder described this as "... *our biggest gap is releasing enough people to do it.*"

Stakeholder interviews suggested those staff interested in dementia were keen to attend the training but encouragement was needed for those without a "*passion*" in this area. While some staff might even view attendance negatively, especially if an exam or assessment were part of the training.

Health Professional Feedback

Health professionals attending the workshops reported to have enjoyed all aspects of the course, finding it "*helpful*", "*informative*" and "*interesting*", and reported the topic areas of strategies for caring for PwD, understanding dementia from a different perspective and understanding different types of dementia had been particularly valuable. In addition, discussions with other staff members, the use of exercises and learning coping strategies were the main positive outcomes of the training.

"Learning to differentiate between [dementia, delirium and depression] and learning strategies to cope with challenging behaviour."

"Meeting other healthcare staff and discussing others experiences of patients with dementia."

"I have enjoyed all of it! It has given me a much better insight into caring for a patient with dementia."

When asked why these aspects had been most useful, health professionals reported that it had been beneficial to update their knowledge on dementia and be able to put this knowledge into clinical practice, understand how to make the patient journey less stressful, reflect on own practice, and learn from other practitioner's experiences.

"Enabled me to reflect on my own practice and of that of others."

"Help me with making their hospital journey as less stressful as possible."

"Helped with understanding particular behaviours the reasons behind it and methods of management."

"This explains their behaviour and put it in perspective, it enabled me to see the world from the dementia patient's view point."

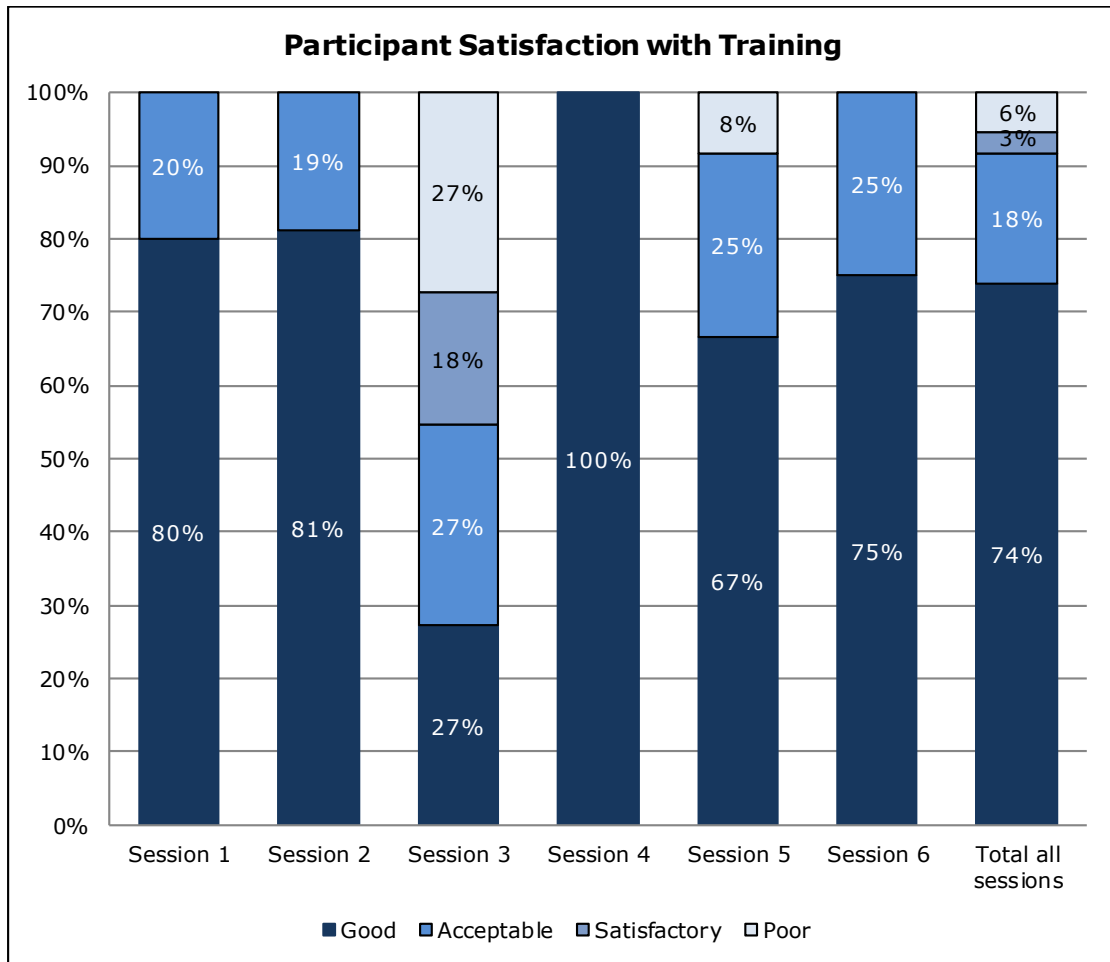
"Practical information that will help me on a day to day basis."

The training was rated highly in terms of satisfaction by the health professionals, with 74% rating it as good and a further 18% as acceptable. Only 6% thought the course was poor, Figure 1 presents the rating of each session and the overall ratings of satisfaction by participants. The main reasons for a poor rating, particularly for Session 3, were the result of inadequate facilities and poor administration more so than course content or delivery.

"Venue was poor with no facilities or adequate parking."

"Misinformed start time."

Figure 1: Ratings of satisfaction by training session



Health professionals were asked to identify the “least useful” aspects of the course, few (n=9) noted that there were any aspects deemed to be “least useful”. Those identified were specific to individuals and there was little consensus here. One health professional reported the day had been “*too in-depth and detailed*”, while another thought “*practical handling*” was a more relevant topic to cover. It was also noted that the training had been “*geared to the psychology of nursing ANY patient – NOT dementia patients*”, which was described as “*disappointing*”. In addition, one health professional considered the final stage of the training had been rushed and not enough time provided for discussions on coping strategies.

Health professionals were asked what they would take away from the training. The key element identified was a better understanding of dementia. Health professionals thought they would be able to transfer the knowledge from the training into practice to improve care, better support PwD, provide support to colleagues and in some cases challenge colleague's behaviour in practice. Professionals referred to having developed an "open mind", a greater interest and keenness to learn more about dementia and increased confidence in treating PwD. The person-centred approach was a successful aspect of the training with health professionals referring to being better able to understand the patient's view point, treating the person as an individual and many reflected on how this would help them in the workplace to improve their own practice.

"Different types of dementia and experiencing dementia from a patient's perspective."

"Helped with understanding particular behaviours the reasons behind it and methods of management."

"Increased understanding of the way in which to promote positive and best practice in dementia care."

Dementia champions

The role of the dementia champions, as explored through the stakeholder interviews, was viewed differently by the Trusts. Some stakeholders saw this role positively, while others thought the roles were a token gesture towards practice change.

Those who were supportive of the champion's role thought they fitted with a new organisational structure within the locality, which will be offering greater

individual services and prospect for inter-professional work. The champion's role was seen to provide the opportunity for good practice to "*trickle through the rest of the team*" and as a way to ensure skills levels within teams were updated.

Stakeholders who were less supportive reported there were already a number of champions within practice for a range of different issues, such as infection control. Their main concern, however, referred to there being no apparent impact on practice as a result of having a champion and the success of the role is often dependent on the individual's level of motivation and interpersonal skills to elicit change. In addition, a stakeholder reported how people do not always feel able to challenge the practices of colleagues or senior staff. The role of a champion can be reliant on the individual being "*prepared to actually take a stand and potentially from time to time... uphold the rights of the people with dementia*", something not everyone will be comfortable to do.

Future training delivery

One of the key findings from this evaluation was in understanding how to take dementia training forward, in terms of future content, delivery style and method.

Gaps in current dementia training provision were identified by both stakeholders and health professionals who stated further training was required in the following topic areas:

- Care of the elderly and dementia (e.g. mobility, falls);
- Challenging negative staff attitudes towards PwD;
- Improving knowledge in the area of end of life care;
- Developing better communication pathways with staff and PwD and their carers;

- Practical management/coping strategies for dealing with PwD;
- Presenting the mental and physical aspects of dementia together;
- Diagnosis of dementia.

The person-centred approach was one adopted by this training and it was this approach which was referred to on a number of occasions during the stakeholder interviews, whether it was referred to as "*holistic*", gaining an understanding of dementia as "*the whole package*" or having a rounded approach. Feedback from the health professionals also supports this view as they reported positively about learning how to "*deal with the patient as an individual person*", or to manage care "*in the patient's best interest*". It seems evident that this should continue to be the focus of future training.

Discussions also focused on the range of staff who should have access to training, such as staff working on the lower bands, qualified staff and specific mention was made to gynaecological staff, general hospital staff, nursing home staff and General Practitioners (GPs).

One of the key recommendations made by stakeholders was that staff should be consulted in order to determine what they identify as their dementia training needs. Overwhelmingly the requirement to train more staff was of key importance and that currently not enough people are accessing dementia training.

In relation to training delivery method, stakeholders felt strongly that training should focus not only on content but also the way in which it is delivered. There was strong support for face-to-face training, be it a whole or half-day, in-team or mix team training, with a slight bias towards a full day's face-to-face multidisciplinary training. This delivery method was thought to offer greater

opportunity for discussions and skills learning, identified by most stakeholders as essential aspects of dementia training. As two stakeholders discussed, when considering the use of online vs. face-to-face training in dementia, their fear was the loss of group discussion if training was delivered via an online system and stressed the need to talk and to question when discussing dementia.

"I've always felt with dementia there's so many things that you have to actually talk about face-to-face and you have to kind of test... You kind of need to have ... that sort of two-way dialogue really to see whether people are really getting it..."

"To lose that discussion, to lose that case scenario work, to lose that, "Oh we had a problem with so and so, how would we then...?" To lose that... For me, that's invaluable training..."

The inclusion of the voice of the PwD was reported to be an important aspect of training in dementia. Whether by video, scenario (as used in this round of training) or in person, this was thought to enhance the training and offer the prospect of new insight and discussion for practitioners. One stakeholder considered the interaction between student and a PwD was important for challenging attitudes and developing a better understanding of dementia.

"... with dementia particularly is it's not just what you read and hear and see on the page or a film, it's how you interact with people and it's the attitudes and behaviours and compassion around dementia..."

Being able to hear from the person directly and listen to their experiences was reported to be a "powerful" way to learn and should be a consideration for future training.

A follow-up training session was suggested by a few stakeholders, thus allowing practitioners the opportunity to digest what they have learnt, put this into practice, and at a later date explore what had/had not worked and discuss areas of best practice. In addition, a follow-up day was thought, by one of the training leads, to provide an opportunity to develop areas of the training further and firm up and support the role of the dementia champions.

"... what I found on other courses is that there's sort of a splurge moment where people just want information and then you can build on it so actually a follow-up day which would look more at management of behaviours and understanding the reasons behind behaviour..."

DISCUSSION

Future Considerations for Training

In this study health professionals and stakeholders suggested a number of areas on which future training provision could focus. The person-centred approach was central to the discussions and perhaps indicates the need to develop this further, with the personal experience from the PwD at the core of any future training.

The structure of future training and delivery method needs careful consideration to ensure the amount of time given to impart the information is achievable. In this study, a follow-up day was suggested by stakeholders to allow health professionals the opportunity to digest their learning and put this into practice, before reconvening to explore what had/had not worked and to share experiences of best practice. Such a follow-up day could provide the opportunity to develop areas of the training and add support to the role of the dementia champions.

Staff training is often time consuming and costly (McNenzie et al., 2000) therefore this evaluation sought to identify the optimum time for training delivery. The full training day format was the most recommended but this was not a universal viewpoint amongst stakeholders. Similarly the face-to-face delivery of training was seen as the most appropriate for dementia training, however, the combination of online training and facilitated session was also suggest as a viable training method.

In conjunction with considering style and length of the training, this study identified perceived current gaps in training provision. Further training in understanding general care for the elderly, being able to challenge negative attitudes towards dementia, improved communication techniques, practical coping strategies for dementia care management and improved knowledge in diagnosis of dementia were the key areas which participants in this study identified. Further to this, gaps in current training provision have been identified by Pulsford et al. (2006) particularly with regards to cultural and social diversity, with those from an ethnic minority or gay/lesbian sexual orientation being ignored in dementia training. The gap in culturally sensitive training is also highlighted by Age Concern (2007), who identify this as a necessity in order to ensure that older people can be cared for adequately.

The training provision, in this paper, originally sought to address an identified dementia knowledge gap of district nurses. Their reported lack of attendance in this training should not be ignored and addressing the reasons for their lower than expected attendance explored further. It was reported that work commitments for this group in particular, impacted on their ability to attend but stakeholder suggestions that the focus of the training may not have met their perceived needs should also be considered. Re-branding the training to encourage

participation would seem one solution, highlighting how it relates to their work and priorities.

Participation of the Person with Dementia

The inclusion of the service user voice, either through video or preferably face-to-face, was considered an important inclusion to future training, by the participants in this study. A study of its members by the Higher Education for Dementia Network, as cited by Hope et al. (2007), found most trainers in dementia care did involve a carer in the delivery of their course but only one trainer included a PwD to support their training.

The inclusion of a PwD in training has a number of ethical considerations, namely adequate informed consent, potential stress and issues of exploitation (Hope et al., 2007). These can be addressed by using more "indirect" methods such as videos, which have also been widely used. There is an argument, as Hope et al. (2007) suggest, that this does not allow participants to adequately hear the voice of the PwD. Further to this Hope et al. suggest that issues of censorship and "inauthentic representations" may abide in the use of such material (2007, p.822). However, the support for the use of such materials is also evident as it offers a way for participants to listen and watch PwD share their experiences, the materials are useable time after time and offer a consistent message. What is clear from this study, is that whether by video or service user involvement, the inclusion of the voice of the PwD or their carer was thought to be an important part of enhancing the training provision and had the potential to lead to new insight and discussion for practitioners.

Multi-professional training

This pilot training was originally aimed at district and community nurses, in reality staff attending were from a mix of health professional backgrounds. This was a positive outcome as it provided a discussion point for practitioners and participants reported an enriched learning environment fostering better understanding between disciplines. This inter-professional approach was popular with practitioners and a number of stakeholders and it was suggested could be an approach to adopt for future training.

The WHO (2012) support the need for collaboration and teamwork across health care professional in supporting PwD and their carers, stating "the multidisciplinary team includes psychiatrists, neurologists, psychologists, nurses, general practitioners, occupational therapists and community/social workers who can share their expertise and collaboration with each other" (WHO, 2012, p.60). Collaborative working is also supported by Age Concern (2007), citing the necessity for a range of occupations to be working together to improve care for older persons. In addition, "cross-training" can offer the opportunity to "overcome the divide between physical and mental health domains" (Age Concern, 2007, p.84), offering a more holistic approach to care of the elderly and in particular dementia care. This multidisciplinary approach to dementia care has seen positive impacts, a three year educational study (Waugh et al., 2011) with a multidisciplinary general hospital team in Scotland, which aimed to improve the care of PwD, found the cross-collaboration between health professionals was a key strength of the study. Positive outcomes in care were observed, through sharing a common and positive language and improved understandings of other staff roles. Improved attitudes towards PwD were noted and better understanding of the person-centred approach adopted.

The need to develop training across a range of levels and job roles has also been identified. A study of higher education dementia training providers revealed that

nurses who do not specialise in mental health have less access to dementia training, regardless of providing substantial care for this group (Pulsford et al., 2006). Alzheimer's Society's (2009b) audit of GPs reported only 31% of GPs thought they had sufficient training in diagnosing and managing dementia. The WHO (2012) also report that GPs admit to a lack of knowledge in diagnosis and communication of dementia, while Age Concern (2007, p.72) state that GPs require "better education and training" for older people with mental health issues. Training amongst staff in acute secondary care is also noted as being poor by 50% of medical staff responding to a census of Community Mental Health Teams (National Audit Office, 2007). The NHS Confederation (2010) report identified that awareness could be developed via internal training and recommend that leads within Trusts are responsible for ensuring dementia training remains on the "agenda". They further recommend that all staff from ambulance staff, hospital porters to catering staff should have access to training.

Limitations of the study

The role of the dementia champions was viewed differently by the stakeholders interviewed in this study. The study was limited as it did not provide a follow-up to understand how the champion's role had been adopted by the health professionals in practice. Concerns regarding the adoption of the role and ability for individuals to adequately tackle potentially sensitive inter-team negotiations have not been clarified and future research would benefit from taking this research further to explore the role of champions within the workplace. Waugh et al (2011) found dementia champions were able to develop better practices with their teams and reported that champions were able to "influence" team members and challenge attitudes. These findings are supported by Manthorpe's (2006) audit of the National Services Framework for Older People's initiative to engage nurse champions for older people. Manthorpe's findings identified the champion

role as enabling staff to work with colleagues across different disciplines, gave them the status to negotiate difficult situations and supported the instigation of changes within their NHS Trusts. The potential for positive outcomes from the role of champions is evident and one which needs to be investigated further.

This study was also limited by its reliance on post training feedback, further research in this area would be enhanced by a review of the training tools and delivery style of the trainers. As Raymond et al. (2013) recommend, in their review of evaluating educational initiatives, fuller detail of the tools and initiatives would provide greater evidence for the effectiveness of training. Further to this, an understanding from the viewpoint of the district and community nurses would have provided a better picture as to why there had been a lack of attendance from this particular group at the training, this is an area which would benefit from further research to better understand their training needs and barriers.

CONCLUSIONS

The aim of this evaluation was to assess the implementation and effectiveness of a dementia awareness training pilot, with a view to informing its future development. There was a high level of satisfaction from those attending the training which indicates the course was well received. Learning can be made from this programme in terms of future training content and delivery design for health professional training, with a focus on person centred care and the adoption of multi-professional training suggested as being considerations for future dementia training.

The marketing of future training provision to health professionals could also be considered to ensure that the aims and objectives of the training are relevant to

the target group and address the impact of the training on practice and for the patient experience.

Further research into the effectiveness of the role of the champions is recommended in order to fully assess the benefits of this training on dementia care and practice and to understand the long term impact of such an initiative.

Training is necessary to help develop the skills and knowledge of staff at all levels of social and health care provision, to challenge the negative attitudes held by many towards dementia (Norbergh et al., 2006), in order to provide adequate person-centred care for PwD and their carers.

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