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Student experiences of taught part-time study on a post graduate dementia studies programme: findings from an electronic questionnaire survey

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Introduction

Introduction

Globally, the number of people living with dementia is estimated to be 46.8 million, forecasted to rise to 131.5 million by 2050 (Alzheimer's Disease International, 2016). Dementia currently affects around 850,000 people in the United Kingdom (UK), 676,000 of whom live in England, with the risk of acquiring a dementia increasing exponentially with age (Alzheimer's Society, 2016). Indeed, around one in four people aged over 80 in the UK have a dementia, mainly Alzheimer's disease, and approximately two thirds of all people with dementia are women (Alzheimer's society, 2014). Of the total number of people with dementia in the UK, two-thirds live in their own homes with the remaining one-third living in a form of supportive accommodation, such as a care home (Alzheimer's Society, 2016). Family carers are the mainstay of the domestic support system for people with dementia living at home, although research indicates that 110,000 carers are themselves aged over 85 and likely to be experiencing at least one long term condition (All-Party Parliamentary Group on Dementia, 2016). Over the last decade, dementia has also risen to be a policy and political imperative with the UK Prime Minister publishing two Challenges on Dementia within a relatively short time-scale (Department of Health, 2012; 2015a) with implementation plans to encourage a more integrated health and social care response and a more dementia-aware society (see for example: Department of Health, 2016).

Against this backdrop, the most recent PM Challenge on Dementia implementation plan to 2020 recognises that education and skills training for health and care staff engaged in the support and care of people living with dementia is crucial in enabling high quality compassionate and culturally competent care to be delivered (Department of Health, 2016). **Indeed, taking hospitals as example, there is evidence that dementia training based on the values of person centred care (Brooker and Latham, 2016) can have a positive impact on factors such as levels of confidence and dementia related knowledge of staff (Elvish et al (2016) and can positively impact on staff attitudes and a "sense of hope" (Surr et al, 2016). Similarly, Argyle and Schneider (2016) found evidence of "knowledge transfer" following an innovative theatre-based learning event, however the authors did not find evidence of this translating into changes to practice and highlighted the problem of the "implementation-gap" and posit that there are contextual barriers and facilitators to the utilisation of learning. This would accord with the findings of a systematic review by Livingston et al (2014) which found that person centred training for care home staff was only effective in reducing levels of agitation in residents when combined with ongoing "ongoing practical and theoretical advice in implementation, rather than initial training only" (p20, 2014).**

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5 Dementia education and training for health and social care staff who work with people with
6 dementia clearly has value even if it may only be one piece of a jigsaw of factors that impact on care
7 outcomes. It is of course important that dementia educational is of high quality and appropriate to
8 the needs of those working with and supporting people living with dementia but in the UK the map
9 of educational provision in the UK is complex. It includes both credit-bearing and non-credit bearing
10 courses. These courses are provided either “in-house”, such as through the care organisation itself,
11 or via contracted external educational provision. External providers can include independent and
12 not-for-profit training providers ranging from individual training consultants to further education
13 colleges and Higher Educational Institutions (HEIs). This diversity of education provision was
14 recently illustrated in an audit of dementia education and training in the two English counties of
15 Hertfordshire and Bedfordshire (Mayrhofer and Goodman, 2016). The audit identified no fewer than
16 85 courses offering either dementia-specific or dementia-related content; of these, only 43 per cent
17 were accredited. Interestingly, much of the delivery and uptake of these courses was described as
18 being focused on staff induction, with less emphasis on those with the levels of responsibility and
19 influence that could lead to changes in organisational culture (Mayrhofer and Goodman, 2016).

20
21 In England, the Dementia Core Skills and Education Framework has set out to encourage
22 “appropriate and consistent” dementia education through the provision of guidance for the delivery
23 of dementia education and training (NHS Skills for Health and Health Education England, 2015). This
24 guidance is in the form of 14 subject headings which range from *Dementia awareness* (Subject 1) to
25 *Leadership in transforming dementia care* (Subject 14). Each subject heading is accompanied by a
26 set of learning outcomes. These outcomes are mapped across three tiers of education which are
27 described as: Tier 1- awareness for all staff; Tier 2- basic skills for staff in settings where there is
28 regular contact with people with dementia; and Tier 3 - where education is targeted at people in
29 specialist roles, including managers and practice leaders. The Department of Health has set a
30 mandate for Tier 1 training to be available to all staff in England by the end of 2018 and for this to be
31 subsequently backed-up by Tier 2 training (Department of Health, 2015b). The format and mode of
32 delivery is not prescribed in the framework and there is, as yet, an absence of a qualifying curriculum
33 for practitioners (Mayrhofer and Goodman, 2016). The mode of delivery of dementia education and
34 training is diverse, spanning, for example, practice-based, classroom-based, online and/or blended
35 learning. Some online courses are open access such as “massive open online courses” (MOOCs)
36 (Goldberg et al., 2015) and there are also freely available materials to support face-to-face learning
37 such as materials produced by Health Education England (2017).

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3 In addition to widely available non-accredited short courses and stand-alone training, a number of
4 HEIs offer credit-bearing dementia education aimed at qualified health and social care staff. HEIs
5 have a significant contribution to make in the delivery of dementia education (Collier et al., 2015)
6 and such education may take the form of undergraduate, pre-registration programmes or continuing
7 education (often credit bearing) courses for qualified health and social care staff.
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11 HEI credit-bearing courses for practising health and social care staff are, by necessity, commonly
12 studied on a part-time basis in order to minimise the impact on service delivery resources.
13 Interestingly, Swain and Hammond (2011) point to a dearth of research into the experiences of
14 mature, part-time students engaged in (any) HEI study, a finding which holds true for health and
15 social care professionals engaged in such study practices (Burrow et al., 2016). Indeed, from the
16 evidence available, the review by Burrow et al. (2016) found that health and social care professionals
17 attending part-time credit bearing HEI courses had both personal and professional motivations to
18 study but demands of attending such courses, such as managing expectations and juggling family
19 demands, had the potential to impact on the quality and depth of student learning.
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23 Given the potentially significant role of HEI dementia educational provision in contributing to the
24 delivery of Tier 2, and particularly Tier 3 training, and the findings of the review by Burrow et al.
25 (2016) indicating the potential challenges experienced by staff undertaking part-time HEI education,
26 there is a need to develop an understanding about how health and social care staff experience such
27 modes of study. A greater understanding of such issues may, for example, inform the field about the
28 development of pre-and post-registration dementia education that is not only appropriate and
29 consistent in terms of curricula content (Alushi et al., 2015), but which is also responsive to student
30 and employer needs and provides the most effective opportunities to promote learning.
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34 This need to better understand student experience shaped the rationale for the electronic
35 questionnaire survey of students on a well-established, credit-bearing, part-time HEI dementia
36 programme in the North West of England.
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39 40 41 42 43 44 45 46 47 **MSc Dementia Care at The University of Manchester**

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49 The University of Manchester has been providing Master's level education in Dementia Care aimed
50 at health and social care professionals since 2003 (Burrow, 2010) and is one of the longest running
51 post graduate dementia programmes in the UK
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54 <http://www.manchester.ac.uk/study/masters/courses/list/06052/msc-dementia-care-apimh/>. The
55 programme curriculum is broadly equivalent to the Skills for Health Tier 3 education. Most of the
56 staff that embark upon the course are qualified to degree level and are already working in
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3 specialist/leadership roles in dementia care, mainly in the North West of England. Until 2016
4 students were funded by Health Education England to complete the programme. The programme is
5 studied part-time via face-to-face, classroom based teaching, but with some additional online
6 elements. The course units which make up the programme curriculum have passed through a
7 number of iterations since the programme started and currently comprise of eight units and a final
8 year dissertation as illustrated in Table 1.
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16 INSERT TABLE 1 ABOUT HERE
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21 Students can exit the programme after the completion of 60, 120 or 180 post graduate credits. The
22 data in Table 2 illustrates the awards graduates have exited with between 2003 and 2014. The 2013
23 cohort graduated in 2016, bringing the total number of graduates to 75, 53 of whom attained a
24 Master's award.
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33 INSERT TABLE 2 ABOUT HERE
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38 **Study aims**

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40 The aim of the study was to examine the experiences of graduates of The University of Manchester
41 Master's programme (MSc) in Dementia Care and specifically to:
42

- 43 • Explore perceptions regarding the impact of the MSc Dementia Care programme with regard
44 to:
45
 - 46 ○ Changes to practice and service development
 - 47 ○ The impact of the programme on personal and professional development
- 48 • Develop an understanding of the student experience with regard to the challenges of
49 undertaking a credit-bearing part-time programme of study
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54 **Methods**

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3 An electronic survey method was chosen to explore student experiences (Evans and Mathur, 2005).
4 This method was selected due to the potential geographical spread of former students and because
5 former students were expected to have no literacy barriers to hinder completion of an electronic
6 survey.
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10 A potential disadvantage of using a survey approach was an anticipated low response. This was a
11 particular concern for this study as it was reliant on having accurate email contact addresses. It was
12 thought that this might be problematic for two reasons; firstly, the time-lag from when some of the
13 earlier cohorts of students completed their studies and the commencement of the survey; and
14 secondly, the possibility that contact email addresses of the sample population may no longer be
15 active.
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20 Participants were all graduates of the MSc in Dementia Care programme at The University of
21 Manchester. To be eligible for course funding, staff attending the course all worked with people
22 living with dementia and practiced in the North West of England. Graduates of the first five cohorts
23 up to and inclusive of the 2011 cohort were to be included in the study (see Table 1). The 2013
24 cohort had not graduated at the time of the survey and were therefore excluded from the sampling
25 strategy.
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30 Only students who had graduated with an award were contacted, therefore students who had left
31 the course in Year 1 without attaining the minimum 60 credits for an exit award were excluded from
32 the survey. Intakes for the course were every two years. Email address records (which may have
33 been active or inactive) existed for 57 of the 66 graduates of the Dementia Care programme from
34 the first five cohorts. An electronic questionnaire survey was distributed via email to these 57
35 graduates. Responses were to be anonymous.
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40 As the questionnaire was specific to the course it was not thought appropriate to draw on pre-
41 existing questionnaires. An electronic questionnaire was developed that would generate both
42 quantitative and qualitative data. Questions were devised by SB and reviewed by the rest of the
43 team. A pilot questionnaire was distributed to three academic members of staff familiar with the
44 programme but external to the writing team. Feedback informed minor alterations to wording of the
45 questions.
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50 The survey comprised 20 questions eliciting both quantitative and qualitative data and was
51 distributed in June 2015 with a closing date for return some eight weeks later. Questions were
52 preceded by an explanation regarding the purpose of the survey. Questions 1-9 were concerned
53 with eliciting demographic information including role, professional qualifications, dates of study,
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3 age, gender, highest level of academic qualification before commencing the programme. Question
4 10 was the first of six open-ended questions inviting a free-text response; it asked participants to
5 describe their experiences of post graduate study. Question 11 asked for details of the participant's
6 exit award and questions 12-13 asked for descriptions of job titles and roles pre and post completing
7 the programme. Question 14 asked respondents to consider if – and how – the course had
8 contributed to career development. Questions 15-17 explored the breakdown in time spent on
9 different activities in professional roles pre and post the programme and questions 18-20 invited
10 free text responses to questions concerning how the course had influenced practice, personal and
11 professional achievements and any other comments on experiences of studying on the programme.
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18 **Ethics**

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20 Correspondence with The University of Manchester Division of Nursing, Midwifery and Social Work
21 Ethics Committee in June 2015 indicated that ethical review was not required for an anonymous
22 course review of this nature.
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26 **Qualitative Data Analysis**

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28 Qualitative data gathered in response to the six open-ended questions was subjected to a thematic
29 analysis following the phases outlined by Braun and Clarke (2006), namely: 1) familiarisation with
30 the data 2) generating initial codes 3) searching for themes 4) reviewing themes 5) defining and
31 naming the themes 6) write-up. As a process, thematic analysis is used to identify and analyse
32 patterns found in qualitative data and the authors used NVivo10 to store and manage the data. In
33 phase 1 of the thematic analysis, all members of the authorship familiarised themselves with the
34 written data. Each member of the authorship then manually generated an initial set of codes from
35 the data. Led by the first author (SB), all members of the authorship then met to discuss, agree and
36 create an initial coding frame (phase 2). The writing team then considered the initial coding frame
37 and met in phase 3 to re-examine the codes against the data transcripts. The purpose of these phase
38 3 meetings was to develop the overarching themes that made sense of the data and underpinned
39 the emergent findings. In phase 4, the generated themes were further refined by SB by looking for
40 any new codes from the data set that had been missed. No new codes or themes were identified
41 and the final set of four themes (phase 5) were agreed as an authentic representation of the data by
42 all members of the authorship. It is the reporting of these four themes that forms the substance of
43 this article.
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55 **Findings**

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3 Of the 57 invitations that were sent out via email to students who had graduated with an award
4 from the first five cohorts of the programme (2003 - 2013), 31 completed responses were received.
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6 This was a return rate of 55%. Nineteen of the 31 respondents were nurses and of these, 14 were
7
8 mental health trained. There were seven occupational therapists and the remaining six respondents
9
10 were from different professional backgrounds including speech and language therapy,
11
12 physiotherapy, counselling, psychology and the voluntary sector. All participants worked – at the
13
14 time of admission to the programme – with people who have dementia.

15
16 The programme attracted a predominantly female student group. Of the 28 respondents who
17
18 identified their gender, 26 were female. The age profile reflects a “mature” student profile: 50% of
19
20 the respondents were aged over 40 years at the commencement of the course and only 6.2% were
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22 aged 30 years or younger. Exit awards of respondents are illustrated in Table 3; 24 of the 31 students
23
24 graduated with an MSc in Dementia Care.

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27 INSERT TABLE 3 HERE
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32 In addition, respondents provided free text responses to six open-ended questions relating to
33
34 experiences and perceived changes of undertaking the MSc in Dementia Care programme. These
35
36 questions were as follows:

- 37 • *Please provide a brief description of your job title and role when you first started the post*
38 *graduate dementia course*
- 39 • *Research shows that being employed and studying part-time on a post graduate university*
40 *course can bring with it a different set of challenges and rewards in comparison to full-time*
41 *undergraduate and/or pre-registration education. Please use this space to tell us about your*
42 *experiences as a post graduate student on this course.*
- 43 • *How has the post graduate dementia course contributed (if at all) to your career*
44 *development?*
- 45 • *Please provide specific examples of how you think the post graduate dementia course has*
46 *influenced your practice with people with dementia and/or their families or staff/services you*
47 *manage or supervise.*
- 48 • *Please detail any achievements since graduating from the post graduate dementia course,*
49 *e.g. promotion, awards, conference presentations, publications etc.*
- 50 • *Please use this space for any other comments you have regarding your experience of*
51 *studying on the post graduate dementia course at The University of Manchester.*

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Themes

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3 From the analysis of the free text responses, four themes emerged: i) juggling competing demands;
4 ii) personal growth and achievement; iii) sources of support; iv) changes to practice.
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9 **Theme 1: Juggling competing demands**

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11 The majority of respondents commented on the challenges of juggling the competing demands of
12 work, study and family. A number of respondents had young children and one had a baby whilst
13 studying on the course. The term “juggling” was frequently used when describing competing
14 pressures that were brought to bear as a consequence of taking on the commitment of part-time
15 academic study. Typical of the comments were: *“I started when my daughter was three years old. It*
16 *was an immense challenge juggling being a mother and studying”* (mental health nurse, 2007
17 cohort) and *“Juggling a full-time job whilst studying was a busy time”* (occupational therapist, 2009
18 cohort).
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26 Simply finding the time, space and opportunity to study was a challenge for many. Respondents
27 commented on the practical difficulties of compartmentalising time to focus on academic work:
28 *“There were rarely long periods of studious concentration, rather, there were hour long bursts after*
29 *the kids went to bed”* (occupational therapist, 2009 cohort) and another respondent who worked
30 shifts in a hospital including nights reported how *“As a full-time worker and carer for family I needed*
31 *to fit in study time at times that were challenging e.g. 2am-5am”* (mental health nurse, 2011 cohort).
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36 The words “overwhelming”, “tiring” and “stressful” were used to convey the pressures experienced at
37 times during the programme of study and in juggling competing demands. Difficulties were
38 exacerbated when students were also experiencing periods of increased demand and pressure in
39 their workplace. Two respondents spoke of working over 50 hours a week in practice. For example,
40 an adult nurse (2011 cohort) commented on the pressures when assignment deadlines coincided
41 with periods of increased demand at work: *“It was stressful as workload in practice was very heavy,*
42 *lots of pressures and the added deadlines of assignments increased pressure”*.
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48 For several respondents, finding the space and time to devote to writing academic assignments
49 necessitated taking annual leave from work, for one respondent (physiotherapist, 2009 cohort)
50 taking a day *“here or there”* was ineffective, instead taking a *“block of time”* was needed in order to
51 complete the work satisfactorily. When juggling competing demands, several respondents spoke
52 about what had to “give way”. For a mental health nurse (2011 cohort) work would take precedence
53 and when something had to be sacrificed it would be time devoted to academic work: *“...work*
54 *pressures tend to make the study feel like a privilege and it’s always the first to give”*. For others,
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3 family life was negatively affected. A mental health nurse (2003 cohort) described how on one
4 particular period on the programme: *"...all my days off and annual leave were focused on the MSc*
5 *requirements...family relationships suffered with having to juggle so many plates"*.
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10 11 **Theme 2: Personal growth and achievement**

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13 Respondents reported positively on what they had gained from the programme. Many commented
14 on the development of skills and knowledge that would inform practice. This comment from an
15 occupational therapist (2003 cohort) was typical: *"I absolutely loved it! Felt like my eyes had been*
16 *opened and was really dissatisfied with the services we provided when I saw what we could be doing.*
17 *But now am really happy with the services we provide because we have developed and changed as a*
18 *result of the MSc".* Similarly, a mental health nurse in the 2009 cohort stated how *"I feel my practice*
19 *is more contemporary and best-practice based with a better underpinning knowledge and rationale*
20 *for the decisions I make", and another nurse from the same cohort described the impact the course*
21 *had on confidence:*
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29 *"(The course) provided me with the confidence and knowledge to seek evidenced based*
30 *solutions to complex issues to improve the care and assessment of clients. I also have skills in*
31 *research & literature reviews. I am confident in challenging opinions of others to improve*
32 *patient experience. I now strive to do more and to change the pathways of services."*
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37 Interestingly, in addition to satisfaction arising from the development of skills and knowledge in
38 dementia care and the impact on practice, a number of respondents expressed how they had
39 developed academic and time-management skills which were a source of personal pride and
40 satisfaction. Thus, although the challenges of academic study and competing demands could come
41 with detrimental costs, as shared in the previous theme, some respondents spoke positively of the
42 acquisition of new skills to manage these events. For instance, an adult nurse (2011 cohort) stated
43 how: *"I became more organised and focused. My time management was important and I became*
44 *more efficient in ensuring tasks and deadlines were met"*.
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52 Many students commented upon the sense of achievement felt at the completion of the course; an
53 occupational therapist (2009 cohort) having described the challenges of juggling competing
54 demands stated: *"However, it was very satisfying to manage to get through the course successfully"*.
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56 Similarly, a mental health nurse (2007 cohort) described how, when they commenced the MSc
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3 programme, her daughter was three years old, and the challenge of being both a mother and
4 studying was “immense”. On the other hand, on graduation, the same student reflected movingly
5 about the sense of pride in her achievement and the ability to somehow mesh these different
6 identities together.
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11 When academic assignments were successfully passed this also brought a sense of satisfaction and
12 accomplishment, but the converse could also be true when assignments were failed: “...when [my]
13 assignments passed it was a great sense of achievement too. When [my] assignments failed it
14 increased stress personally and professionally” (district nurse, 2009 cohort). This latter point is
15 interesting as it hints at the impact academic success, or failure could have on professional roles in
16 the workplace and this may add additional pressure to succeed.
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23 **Theme 3: Sources of support**

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25 Respondents were not specifically asked about sources of support whilst studying, but a number of
26 responses clearly identified supportive and unsupportive factors; the workplace being a key factor. A
27 particular issue was the availability of time respondents were allotted by their employers to engage
28 in study. In order to be accepted onto the programme, employing organisations were contracted to
29 release their employees for one-day per week to attend lectures during term-time, but any
30 additional study time was discretionary.
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36 Where additional study time was made available by employers this was highly valued: “I was lucky as
37 my employers always gave me both the study day to attend the course teaching and an additional
38 day to undertake the work” (occupational therapist, 2007 cohort), but for a number of respondents,
39 this was not the case: “My employer at the time did not acknowledge or encourage my learning.
40 They possibly saw it as a threat. This was very frustrating for me” (speech and language therapist,
41 2011 cohort). Furthermore, an occupational therapist (2009 cohort) commented on how s/he was
42 “Unable to do any study...in work – all done in my own time”. The variations in the support received
43 by students from their employing organisations to facilitate course attendance and additional study,
44 created an inequality in student experience.
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51 The support provided by University tutors for academic and health and welfare matters was
52 highlighted by a number of respondents: “I could not fault the support I received from tutors on the
53 course itself who were always readily available to support when I felt under pressure” (mental health
54 nurse, 2011 cohort), whilst another respondent with caring responsibilities for a close family
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3 member shared how: *"...my supervisor on the course provided support when needed" (learning*
4 *disability nurse, 2009 cohort).* However, in order to receive support, it was sometimes necessary for
5
6 students to acknowledge it was needed in the first place and that it was permissible to seek and
7
8 accept help. This dilemma/conflict is shared in the following example from the data: *"I had never*
9 *asked for an extension or for mitigating circumstances to be taken into consideration as such things*
10 *had not been part of my previous experience of education, but I was helped to recognise that as a*
11 *mature, working student sometimes life intervenes and it is ok to say so"* (occupational therapist,
12
13 2009 cohort).

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17 In addition to the availability of supports from the workplace and the University itself, it might be
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19 reasonable to have expected respondents to comment upon the presence, or absence, of support
20
21 from partners/friends/family. Interestingly, such sources were not mentioned and the influence of
22
23 family was only highlighted in the context of juggling competing demands, as in theme 1.

24 25 26 **Theme 4: Changes to practice**

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29 The majority of respondents directly commented on how attendance on the course had enabled
30
31 them to develop their own practice and instigate change, and many direct examples of practice
32
33 development were given. An Occupation Therapist (2009 cohort) stated:

34
35 *"I think my understanding of behaviours that challenge and positive risk taking greatly*
36 *improved. I feel I manage to meet the needs of people with complex needs better & have*
37 *facilitated people to go home where many of the multi-disciplinary team felt they needed 24*
38 *hour care."*

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43 Another Occupational Therapist from the same cohort reported how their dissertation on driving
44
45 issues focused interests in this area, and as well as conducting an audit on driving with dementia and
46
47 collaborating on a research study, they were currently *"... in the process of developing a protocol and*
48 *way of working as OTs with an off-road screening tool and have developed links with a North west*
49 *driving assessment centre."*

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51
52 A mental health nurse (2009 cohort) and manager of a specialist unit for people with dementia who
53
54 have challenging needs described how the course *"...has allowed me to develop the unit I manage*
55 *into a well-regarded resource"* and an Occupational Therapist (2003) cohort described how the
56
57 course had empowered them into leading a number of service development changes namely:
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59 *"Setting up post diagnostic support, setting up peer support, developing involvement of people with*
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3 *dementia within the organisation, never teaching or presenting without people with dementia*
4 *involved, this has led to wider involvement within Dementia Action Alliance.”*
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8 Others expressed enhancement to practice in more general terms, as this slice of data attests:
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11 *“The benefits have been tenfold, my confidence in practice has grown, my critical analysis*
12 *developed and I feel my mind is more enquiring. It was really helpful to be able to sit in a*
13 *classroom and then apply the knowledge almost immediately the next day in the clinical*
14 *setting and this brought rewards”* (mental health nurse, 2007 cohort).
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19 Similarly another respondent stated how: *“The rewards were immense - giving space to think more*
20 *widely about my clinical practice, the ward environment, the experience of people and carers or*
21 *relatives of people with dementia, lifting my head above the parapet and having a break from the*
22 *fire-fighting of clinical practice in the NHS”* (occupational therapist, 2009 cohort). Comments were
23 also made about how a growing sense of confidence and expertise helped in influencing other staff
24 and there was kudos from attending the course: *“Because I was studying dementia care, colleagues*
25 *valued my input more and my suggestions became more credible”* (adult nurse, 2011 cohort).
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32 There were a number of comments relating specifically to how attitudes and values had shifted as a
33 result of undertaking the course, most notably in respect of focusing on rights and empowerment of
34 people living with dementia:
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38 *“Although I worked in dementia care for many years and felt myself to be an empowering*
39 *practitioner I do think that I was paternalistic. The course very much moved me from that*
40 *approach and the work around empowerment and citizenship in particular was powerful”*
41 *(mental health nurse, 2011 cohort).*
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47 Similarly, another respondent stated how: *“I no longer see health and social care services as central*
48 *to the wellbeing of people with dementia; I believe that their social network is just as important”*
49 *(speech and language therapist, 2011 cohort).*
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53 Finally, the sharing of knowledge, ideas and innovative methods of practice was frequently
54 highlighted, and this was connected with increased confidence through having attended the
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programme and developing new skills to draw on research and theoretical evidence-base to underpin and drive changes to practice:

"I think looking more at the social aspects rather than the medical aspects of the condition influenced my practice as it enabled me to think about developing dementia cafes and using music and singing as an alternative to promote well-being for both the person with dementia and their carers. The course also gave me the evidence to do work I was interested in and had (previously) tried to implement without much success due to negativity and stigmas. For example I was interested in the effects of doll therapy and tried to introduce this onto the wards. The response was very negative from staff but having the evidence to back me up made this more do-able." (mental health nurse, 2003 cohort).

Discussion

The findings revealed that graduates of the Dementia Care MSc programme felt they had made gains in terms of knowledge, confidence and shifting perspectives and attitudes; and this had led to achieving changes in practice. This would indicate that intermediate and more advanced levels of dementia education can lead to changes in practice and service delivery. The personal satisfaction of successfully undertaking and completing the programme was also very evident. However, respondents clearly faced significant challenges when it came to undertaking part-time learning and these challenges require serious consideration from education providers, commissioners and employing organisations alike.

The demographics of the respondents to the study reflects that of the health and social care workforce more widely; the study population was just over 80% female which matches the wider non-medical NHS and social care workforce (King's Fund, 2016; Skills for Care, 2015). In terms of age, 94% of respondents were over 30 years of age and 50% over 40. In England 1:5 of the social care workforce are over 55 (Skills for Care, 2015). There are implications to this demographic profile. In the reported study, no specific questions were asked with regard to caring responsibilities, but it was evident from responses that many respondents did have children, or caring responsibilities for older family members, and juggling such competing demands was a major challenge. Other studies have shown how caring responsibilities can be "constraining factors" when it comes to engaging in higher education (Swain and Hammond, 2011) and respondents in this study spoke of the demand of juggling care and family life with the demands of study. This could result in stress and tiredness and there were some descriptions of how either academic work, or family life, could suffer as a

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3 consequence. Moreover, we would suggest that the study and intersection of gender in course
4 attendance and educational performance requires a much higher profile going forward.
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7 Another significant area for consideration arising from the study was pressure at work. At the time
8 of undertaking the MSC in Dementia Care, all respondents were involved in either full or part-time
9 work in health or social care settings, and this formed a significant aspect of juggling competing
10 demands, as shared in theme 1. Employing organisations could alleviate some of these demands
11 through more supportive practices, including allowing additional study time for students. There
12 were indications from the data that workplace practices on this issue varied widely. Accordingly,
13 there are implications here for practice both in terms of academic programme design and employer
14 practice. This specific post graduate course was delivered in the format of classroom based learning
15 – with students released from work to attend the university one day per week during academic
16 terms – with some additional on-line learning. There may be a case for delivery to wholly on-line or
17 “blended” in order to offer greater flexibility.
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20 However, some caution should be urged. In a qualitative study of 15 experienced social care
21 practitioners who attended part-time study on a course in Ireland, the development of supportive
22 relationships between each other was a key source of support in what was experienced as an often
23 challenging transition to becoming a student, although time was needed for these relationships to
24 develop (McSweeney, 2014). McSweeney also highlights how a positive caring culture within the HEI
25 with good tutor/student relationships and sensitive feedback and appropriate academic supports
26 were all viewed positively. Whether these supportive relationships and practices are as easily
27 achieved via on-line rather than face-to-face learning would need to be considered. However, it was
28 interesting to note in this survey that where students compared taught elements of the course, that
29 units involving face-to-face, classroom-based sessions were preferred over those over units utilising
30 online study. Further research is needed to explore how students experience different forms of
31 taught provision and those elements that are perceived as being most supportive and facilitating of
32 effective learning.
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50 **Limitations**

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52 A clear limitation of the survey was the response rate of 55%. It is likely that a number of the contact
53 details for former students were out of date and not all of the invitations received. However, over
54 half of all students who had graduated from the programme did participate and as such the findings
55 do hold some value. The sample was purposive in that it was restricted to people who had
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3 completed a specific course and as such, caution should be applied if attempting to generalise the
4 findings and apply to experiences of part-time, post graduate health and social care or dementia
5 study more widely.
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9 Another limitation of the study was the decision to exclude students who had dropped out of the
10 course in the first year of study, prior to obtaining the 60 credits needed for the post graduate
11 certificate. It would be interesting to explore factors that led to students leaving the course and to
12 compare and contrast with the difficulties and means of coping of those who succeeded in exiting
13 with an award.
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20 **Conclusion**

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22 There is a clear need to extend the reach of appropriate and consistent dementia education for
23 health and social care practitioners. Staff targeted in all three tiers of education detailed in the
24 Dementia Core Skills and Education Framework (NHS Skills for Health and Health Education England,
25 2015) have a need for high quality education that meets the appropriate learning outcomes.
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30 **This study indicated that intermediate and advanced credit-bearing dementia education can have a**
31 **positive impact on attitudes, confidence and can lead to changes in practice. This was however a**
32 **small-scale study and further research is necessary to explore how such advanced levels of dementia**
33 **education can influence practice and service delivery and, in particular, what the barriers and**
34 **enablers are to utilising knowledge and leading/enabling change.**
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39 **Additionally, this study has highlighted** how courses need to also take account of the characteristics
40 of the student body and recognise – and make adjustments for – the challenges staff experience
41 when they take on additional, and often demanding post graduate part-time study. Consequently,
42 educational programmes and employing organisations need to develop flexible, supportive and
43 educationally effective opportunities for study. This modest survey has highlighted some specific
44 challenges staff experience when engaging in part-time HEI education, but further research is
45 needed to build understanding about the difficulties faced and, more importantly, how students
46 manage these difficulties and find the most effective supports. These understandings will be
47 necessary to inform the development of student-centred education and meet the aim of improving
48 dementia education and contribute towards safe, effective care, support and empowerment for
49 those with the lived experience of dementia.
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Table 1: MSc Dementia Care programme structure

Year 1	Year 2	Year 3
Perspectives on dementia (15 credits)	Evidence based practice in dementia care (15 credits)	Dissertation (60 credits)
Critical appraisal and evidence synthesis (15 credits)	Research design (15 credits)	
Dementia and social inclusion (15 credits)	Crisis and complexity in (15 credits)dementia care	
Communication through person centred practice (15 credits)	Developing practice and managing change (15 credits)	
Exit point: post grad cert (60 credits)	Exit point: post grad diploma (120 credits)	Exit point: MSc (180 credits)

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Table 2: MSc Dementia Care programme exit awards

Year of Entry (cohort)	PG Cert	PG Dip	MSc
2003	2	4	10
2005	0	4	6
2007	0	3	8
2009	3	2	11
2011	1	2	10
2013	0	1	8
Total	6	16	53

Table 3: Exit awards and professional roles of survey respondents

Year of Entry	PG Cert	PG Dip	MSc	Professional role
2003	1	0	3	3 nurses; 1 occupational therapist
2005	1	0	2	2 nurses; 1 speech and language therapist
2007	0	0	4	3 nurses; 1 occupational therapist
2009	1	2	7	4 nurses; 5 occupational therapists; 1 physiotherapist
2011	1	0	9	7 nurses, 1 speech and language therapist, 1 assistant clinical psychologist; 1 counsellor
Total	4	2	25	