What is the impact of the Allied Health Professional Dementia Consultants in Scotland?

An evaluation commissioned by Alzheimer Scotland

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It has been a pleasure to work with you all.

A note about terminology

Throughout this report, the term, ‘the Consultants’ will be used to refer to the AHP Dementia Consultants.

Foreword

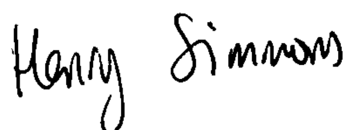
Since dementia was made a national priority by the Scottish Government in 2007, Alzheimer Scotland has been an active partner and critical friend supporting the design and implementation of two dementia strategies. This partnership approach was extended in 2012 to work with the Chief Health Professions Officer in Scottish Government to work in partnership with allied health professional colleagues in both the NHS and social services.

As an organisation over the past three years we have seen crucial role of the allied health professionals as dementia champions, their contribution to post diagnostic support and their role to integrated community support. They have shared this with the public through three publications, developing an AHP leaflet in partnership with the professional bodies and sharing their skills and expertise on social media. All have been developed to inform and support the delivery of our commissioned work for commitment 4 of Scotland's dementia strategy, of an evidence based policy on the AHP contribution to the key messages in Scotlands Dementia Strategy. This current research will also inform this AHP evidence based policy document.

This evaluation is robust and timely, at a time of transformational change in dementia in Scotland. The research focuses on the role of the Allied Health Professional Dementia Consultant; setting out what is working well, offering ideas on the way forward to ensure that the progress that has started in AHP practice continues.

The AHP Dementia Consultants, as senior strategic leaders of transformational change working alongside Alzheimer Scotland dementia nurses, dementia champions and the recently established Alzheimer Scotland AHP Dementia expert group, are a substantial force for change and for delivering improvement in dementia in Scotland. The AHP Dementia Consultants are a valued resource and this evaluation demonstrates they have been highly effective leaders who have increased knowledge skills and good dementia practices in targeted settings

Much has been achieved with the current leadership models in allied health professionals however we have still much to do. We will work alongside our partners going forward, looking at the detail of this evaluation, integrating the findings in commitment 4 to maintain a strategic direction and support the transformational change of allied health professionals to enable their therapeutic skills and expertise to be realised for people living with dementia and their carers.



Henry Simmons, Chief Executive, Alzheimer Scotland

Executive summary

In January 2015, Alzheimer Scotland commissioned an evaluation focusing on the role of the Allied Health Professional [AHP] Dementia Consultant [hereafter, 'the Consultant'] – a position funded by the Scottish Government.

There are four Consultants in Scotland – three based in local NHS boards and one in Alzheimer Scotland. The three posts in the territorial health boards have been funded since 2010. The Alzheimer Scotland post has been funded since 2012.

About the evaluation

The purpose of the evaluation was to identify the Consultant's impact – actual or likely – on the organisations in which they work, on Allied Health Professionals working across Scotland, and on people living with dementia. As well as aiming to identify impact, the evaluation was to uncover views on what has worked well and less well, and why. The findings were intended to inform work being undertaken by Alzheimer Scotland in addressing Commitment 4 of Scotland's Dementia Strategy.

The evaluation was outcome-focused [i.e. focused on what the Consultants had achieved] and theory-driven [how the Consultants achieved these outcomes]. A logic model was developed in advance, and the short-term outcomes set out in the logic model provided a framework for the evaluation.

Evaluation methods included: depth interviews with the Consultants; interviews with key national and local stakeholders; a survey of AHPs across Scotland; and interviews with a sample of the survey respondents.

It is important to emphasise that the evaluation sought to understand the impact of the Consultant role. It was not a performance appraisal of the four individuals involved. Therefore, the findings concentrate on the effectiveness of the Consultant role rather than seeking to differentiate between, and report on, individuals.

Key findings

Feedback from the national and local strategic stakeholders was overwhelmingly positive: they talked of Consultants' successes in ways that were consistent with the outcomes defined in the logic model. Moreover, when they talked about what the Consultants actually did [their activities], they built a convincing case for these outcomes having been achieved [in full or in part] *because of* Consultant involvement.

The Consultants were considered to have been highly effective as leaders within their own key result areas, not simply raising awareness but also increasing good dementia practices in targeted settings, and across a range of organisations. There was consensus this leadership role provided a platform to progress work and to lead change that would not otherwise have happened.

The Alzheimer Scotland AHP Expert Group, convened by the national Consultant and comprising representatives of the AHP 'community' from local authorities, NHS boards and professional bodies, was considered to be an important part of the picture. Through its involvement, not only had the strategic profile of AHPs been [further] promoted, but greater strategic buy-in was also believed to have been achieved across Scotland.

Evaluation participants highlighted evidence of increased joint working between AHPs and Link Workers, and of strengthening relationships between the third sector and the universities involved in AHP education. The important role of Alzheimer Scotland in supporting this work was seen as a factor that had contributed to its success.

The survey findings and interviews with AHPs suggested that although the reach of the Consultants among the wider AHP workforce has been somewhat limited, their impact among those they *have* reached has been substantial. AHPs gave numerous examples of how their knowledge, skills and practice had changed as a result of their contact with the Consultants. It is particularly notable that AHPs who reported some form of contact with the Consultants were **more** likely than those who did not, to say that they had: [i] learned about new approaches in the last 24 months; [ii] had found those approaches very useful / relevant to their work; and [ii] had incorporated those approaches regularly into their own practice.

There was also evidence that the Consultants had played a role in bringing about a deeper understanding – within services and within AHPs themselves – of how AHPs can contribute to the care and support of people living with dementia by getting involved at an *earlier* stage in a person's care. The findings of this evaluation suggested that AHPs are beginning to understand this role, and that services (particularly acute services) are also beginning to recognise the benefits of involving AHPs earlier.

Finally, there was praise among the national stakeholders for what the Consultants had achieved in raising awareness among community organisations and services about the need to tailor approaches to better support people living with dementia. This aspect of the Consultants' work was about making dementia everyone's business. There was also some modest evidence of this message being spread by AHP dementia champions in their local areas.

It is perhaps too early to consider whether the Consultants' work has impacted positively on people affected by dementia in a significant way: their focus in the short-term has been primarily about building AHP capacity, capability and leadership. Nevertheless, given that: (a) the Consultants' work was considered to be relevant and useful, and (b) changed practices were reported, it is highly plausible that improved experiences and outcomes for *some* people affected by dementia may have come about because of this work.

While national and local stakeholders commented that there will be limitations in how much can be achieved by four Consultants since the establishment of the role, it was notable that a high percentage of survey respondents were unaware of the outputs produced by the Consultants and/or had had no contact with any of them. This is perhaps unsurprising as the Consultants were often reliant on other conduits to reach AHPs across Scotland. However,

as noted above, the survey findings also indicated that those who were familiar with the content of the three Consultant-produced publications considered them to be relevant.

Some developments to date were considered to be sustainable, most notably those focused on increasing capacity and capability of the AHP workforce, and those that had a high level of interagency buy-in such as dementia friendly communities. At a national level, the Alzheimer Scotland AHP Expert Group was seen to be pivotal; therefore, a need to maintain [and fund] this 'collective collaboration' was identified. Moreover, it was felt that the momentum across the full range of the Consultants' intended outcomes would best be achieved through continuation of the posts.

Conclusion

It is suggested that any future deployment of the Consultant role should take an outcome-focused approach. This should involve consensus building on the changes that the Consultants intend to achieve, and be partnered with sound, proportionate and ongoing monitoring and evaluation. Doing so will not only enable assessments of where changes are being made and to what level, but will also provide a stronger basis for making decisions on whether and how activities should be refined. Doing so will strengthen both evidence and effectiveness on the AHP workforce's contribution to a Scotland in which people affected by dementia flourish for longer.

1. Introduction

This is a report of an evaluation focusing on the role of the Allied Health Professional [AHP] Dementia Consultant [hereafter 'the Consultant'] – a position funded by the Scottish Government.

There are four Consultants in Scotland: three are based in local NHS boards and one in Alzheimer Scotland. The three posts in the territorial health boards have been funded since 2010. In 2012, these were complemented by the addition of a further Consultant post hosted by Alzheimer Scotland.

The evaluation reported here was commissioned by Alzheimer Scotland and carried out between January and April 2015.

1.1 The national context for the AHP Dementia Consultants

It is estimated that there are currently around 90,000 people in Scotland with dementia.[1] Moreover, demographic changes, in particular, an increasing older population, mean that the number of people in Scotland with dementia is expected to double between 2011 and 2031.

In acknowledgement of the scale of this need, the Scottish Government has made the diagnosis, care and support of people with dementia [and their carers] a priority. Scotland's first dementia strategy was published in 2010, and a refreshed strategy [for 2013-2016] was published in May 2013.[2]

The current dementia strategy sets out the agenda for the Scottish Government and its partners in NHS Scotland, local government and the third and independent sectors, and identifies five key challenges which need to be addressed to improve the life of people living with dementia, their families and carers. These challenges were:

- Fear of dementia that means people delay coming forward for a diagnosis.
- Information and support after diagnosis is poor for people living with dementia, their families and carers.
- General healthcare services do not always understand how to respond to people living with dementia, their families or carers, leading to poor outcomes.
- People living with dementia, their families and carers are not always treated with dignity and respect.
- Family members and people who support care for people with dementia do not always receive the help they need to protect their own welfare to enable them to go on caring safely and effectively.

[1] See Alzheimer Scotland website: http://www.alzscot.org/campaigning/statistics
[2] Scottish Government (2013) *Scotland's National Dementia Strategy: 2013-16.* See http://www.scotland.gov.uk/Resource/0042/00423472.pdf.

Building on the on the achievements of the first strategy, the focus of the current strategy is on:

- Offering care and support to people with dementia, their families and carers in a way which promotes wellbeing and quality of life, and which protects their rights and respects their humanity.
- Providing truly person-centred care and support for people and their carers throughout the course of their illness.
- Redesigning and transforming services to ensure that services are being delivered effectively and efficiently.

The national strategy continues to emphasise the need for improvements in acute general hospital settings as well as post-diagnostic support, the latter informed by Alzheimer Scotland's "5 Pillars" model of post-diagnostic support.[3] This is reinforced through specific HEAT [health improvement, efficiency, access and treatment] targets relating to early diagnosis and post-diagnostic support.

In addition, the current strategy highlights the need to move more towards a system of care that promotes the resilience and independence of individuals living at home during the moderate to severe stages of the illness. It asserts a commitment to test and evaluate a range of approaches for providing better integrated care and support on the basis of the "8 Pillars" model of Community Support that is promoted by Alzheimer Scotland.[4] The strategy includes a commitment [commitment 4] to commission Alzheimer Scotland to produce an evidence-based policy document outlining the contributions of AHPs to ensuring implementation of the 8-Pillar model.

Implementation of the dementia strategy is further supported by action to increase capability in the workforce. Core to this is *Promoting Excellence* – a knowledge and skills framework for all health and social services staff working with people with dementia, their families and carers.[5] *Promoting Excellence* details the knowledge and skills to which *all* should aspire in relation to the role they play in supporting people living with dementia. *Promoting Excellence* is intended therefore to [also] support NHS Boards in meeting the *Standards of Care for Dementia in Scotland.*[6]

1.2 The role of Allied Health Professionals in dementia care and support

Allied Health Professionals [AHPs] are a distinct group of 12 professions who apply their expertise to diagnose, treat and rehabilitate people of all ages across health, education and

[3] http://www.alzscot.org/campaigning/five_pillars
[4] http://www.alzscot.org/campaigning/eight_pillars_model_of_community_support
[5] Scottish Government (2011) Promoting Excellence: A framework for *all* health and social services staff working with people with dementia, their families and carers The Scottish Government Edinburgh
[6] Scottish Government (2011) Standards of Care for Dementia in Scotland The Scottish Government Edinburgh

social care. AHPs range from art therapists to paramedics to dieticians. Physiotherapists and occupational therapists comprise the largest two groups of AHPs.[7]

Since the introduction of the Consultant role in 2010, there have been a number of key strategy documents in addition to the national dementia strategy mentioned in the previous section. Notable strategies include [but are not restricted to]:

- *Realising Potential - the action plan for allied health professionals [AHPs] in mental health [2012]*[8]
- *AHPs as agents of change in health and social care - The National Delivery Plan for the Allied Health Professions in Scotland [2012 – 2015]*[9]
- *Driving Improvement: Implementing Realising Potential - An action plan for allied health professionals in mental health [2014]*[10]

Realising Potential provided strategic direction for AHPs in relation to mental health generally. It pointed to the contributions that AHPs can and do make across different services, and critically – it focused attention *across* the [mental] health care pathway and did so not only in relation to the management and treatment of symptoms but on promoting *wellbeing* too:

> *Realising Potential doesn't ask AHPs to do extra. It asks AHPs to do differently... It is about harnessing AHPs' creativity and energy and focusing them on meeting individual needs across the spectrum of service delivery…. it attempts to understand the entire journey a person and his or her carers make through mental health services and to identify at which points AHPs can make the most meaningful contributions not only to alleviate symptoms and distress, but also to promote well-being and mental health improvement for individuals.*[11]

To assist in implementation of this strategy, each territorial NHS board has a defined AHP mental health clinical lead. However, this strategy also welcomed AHP leaders who were coming up through the ranks and who were focused on improving the care and support that people receive from services.

There is a strong policy context reinforcing the important contributions that AHPs offer in relation to dementia care and support more specifically. Thus, the national dementia strategy points to the role of AHPs in its delivery, noting the growing evidence base supporting active non-pharmacological interventions delivered by AHPs.

In view of this growing evidence base, the dementia strategy includes a commitment to 'work with Alzheimer Scotland and AHPs to produce an evidence-based policy document that will outline the contribution of the AHPs to the 8-Pillar model [and the contribution of

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[7] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/qw_focus_on_ahps.pdf, see page 9 for information about the numbers of AHPs registered with the Health and Care Professions Council in 2013.

[8] http://www.gov.scot/Publications/2012/03/4716/1

[9] Scottish Government (2012) *The National Delivery Plan for the Allied Health Professions in Scotland, 2012–2015*. See http://www.scotland.gov.uk/resource/0039/00395491.pdf

[10] http://www.gov.scot/Resource/0045/00458245.pdf

[11] http://www.gov.scot/Publications/2012/03/4716/1

the AHPs to the key messages in the Dementia Strategy].' The 8-Pillar Model is focused on building the resilience of people with dementia and their carers to enable them to live in the community for as long as possible.

The strategic and operational contributions AHPs make to progressing this policy agenda is clearly set out in the national delivery plan for Allied Health Professionals in Scotland *[2012 – 2015]*[12]. This delivery plan promotes *AHPs* as agents of change in health and social care*,* highlighting the crucial role that AHPs have to play in providing – and co-ordinating – more integrated care for people with dementia. The delivery of more "enabling" services, and the emphasis on self-directed care and supported self-management and resilience, are seen to be vital in achieving better outcomes for people with dementia who use services, their families and carers. The point is made that AHPs have an important **leadership** role in this.

> *AHPs have the expertise to support people with dementia, their families and carers to live well with the condition through the promotion of supported self-management and provision of specialist functional assessments and environmental adaptations. They are well-positioned to lead on reablement, early and post-diagnostic intervention but will need support to build capacity and capabilities in and across sectors to enhance care pathways for people who use services, their families and carers. [The National Delivery Plan for the Allied Health Professions in Scotland, 2012–2015, pp. 16-17]*

Crucially, as indicated in this extract, while AHPs are well-positioned to provide leadership, this will require cross-sector buy-in with a focus on early interventions and timely access reiterated in *Driving Improvement.*[13]

1.3 The creation of the AHP Dementia Consultant post

In 2010, territorial NHS boards were invited to bid for Scottish Government funded AHP Dementia Consultant posts. This was a newly established post with an overall aim to 'implement local small tests of change that can then be shared nationally and can demonstrate sustainability'.

Following a competitive tendering process to host a Consultant post [which attracted eight submissions], the Scottish Government drew up memoranda of agreement with three territorial NHS boards:

- NHS Greater Glasgow and Clyde
- NHS Lanarkshire
- NHS Lothian

These agreements shared a number of core responsibilities [as detailed in Box 1, over] and also outlined local priorities and associated activities and deliverables.

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[12] Scottish Government (2012) The National Delivery Plan for the Allied Health Professions in Scotland, 2012–2015. See http://www.scotland.gov.uk/resource/0039/00395491.pdf

[13] http://www.gov.scot/Resource/0045/00458245.pdf

Box 1. Extract from the memoranda of agreement with territorial NHS Boards: cross-cutting responsibilities for the AHP Dementia Consultants in the territorial health boards

The Allied Health Professions Consultant will:

- Develop a shared service model in partnership with all key stakeholders and review the contribution of the AHP's in the patient pathway enhancing current models of working, consider new models of working and their contribution to the key messages in the Dementia Strategy, the new mental health strategy and the AHP Delivery plan
- Share information nationally in partnership with the other AHP Consultant Posts in Dementia Care and other key stakeholders
- Provide clinical leadership and maximise the impact of the allied health professionals in dementia care in partnership with others and an emphasis on the integration agenda
- Progress on the key result areas highlighted in the job description and work plan with an emphasis on measuring the impact on service delivery for the person with dementia and their carers and families
- Play an active part in the National AHP and Nurse Dementia Consultants Group development programmes and local, regional and national action planning to align and extend dementia practice
- Ensure that all patients / families are provided with information appropriate to their needs and existing level of knowledge; providing advice, education and information on accessing direct routes to community based supports such as Alzheimer Scotland Dementia Helpline and other relevant services
- Establish partnerships and strong working relationships with key stakeholders in Local Authorities, Primary and Community Care, Voluntary and Independent sectors.

The role of Consultant was initially developed and co-ordinated by the AHP Advisor in Mental Health within the Scottish Government. That co-ordinating role [and the individual performing it] was subsequently transferred to, and hosted by, Alzheimer Scotland on behalf of the Scottish Government.

1.4 Evaluation aims and objectives

This evaluation was commissioned to inform the work being undertaken by Alzheimer Scotland in addressing Commitment 4 of Scotland's Dementia Strategy. Its aim was to identify the Consultants' impact – actual or likely – on: the organisations in which the Consultants work; AHPs, and people living with dementia.

As well as aiming to identify impact, the evaluation was to uncover views on what has worked well and less well, and why.

2. Evaluation Methods

2.1 Overview

The evaluation was outcome-focused, i.e. it focused on what is being achieved, and is likely to be achieved [outcomes] rather than focusing simply on what the Consultants have been doing [their activities].

The evaluation was also **theory-driven**. What this means is that it focused not only on **what** the Consultant role was expected to achieve but also **how,** i.e. the inherent theory or set of beliefs about how the Consultant activities are expected to lead to, and result in, a projected series of outcomes being met.

The outcome-focused theory-driven nature of the evaluation therefore needed to be underpinned by an informed understanding of the specific changes that the Consultants independently and/or together, were seeking to achieve and their 'theory' about how they were going to achieve these. This required clarity on:

- What 'success' would look like not just in the long term but in the shorter term too [i.e. intended outcomes]
- How previous and planned activities were expected to lead to the projected chain of outcomes being achieved
- Any key contextual factors and assumptions which underpin the 'logic' of the connections between what was being done [activities] and what was expected to be achieved [short-, medium, and long-term- outcomes].

At the project's outset, we therefore developed **a logic model.**

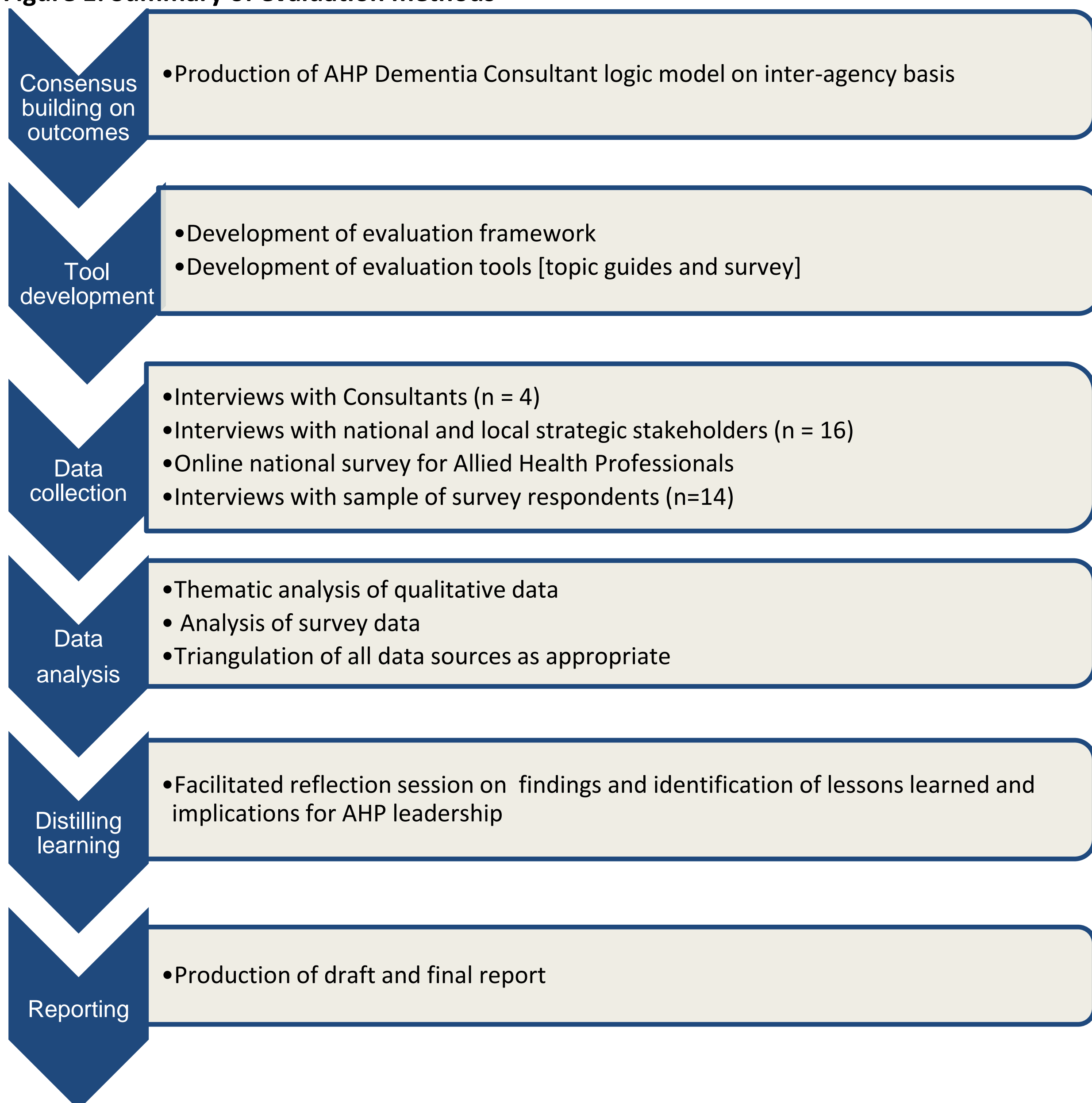
About logic models

A logic model is a convincing [or plausible] picture which shows how activities are linked with intended results. Logic models can be used for a wide range of purposes. They can be used to:

- Build consensus and communicate an [agreed] vision and plans
- Show how plans link with [and contribute to] a bigger picture
- Consider the assumptions that are being made – and reflect on how appropriate or valid these are
- Provide a framework for monitoring and evaluation – by detailing areas/issues that could be recorded to assess whether an intervention is being delivered as intended and whether it is achieving its intended results.

This model was then used as a framework for a mixed-method evaluation. Each step of the evaluation methods is described below. For clarity, these steps are summarised in Figure 1 [over].

Figure 1: Summary of evaluation methods

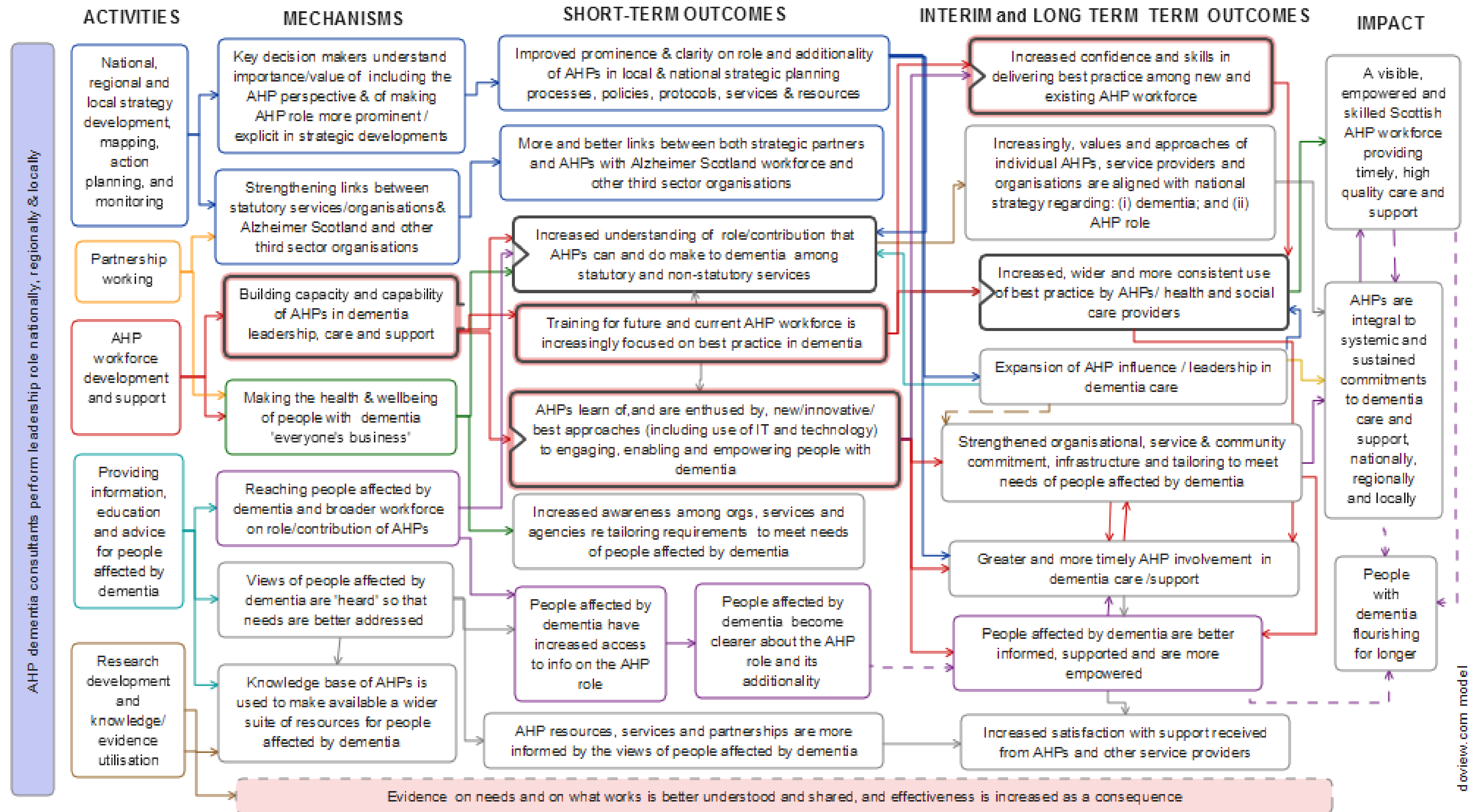


2.2 Developing the logic model

To reach consensus on what the Consultant role was meant to achieve and how, two half-day logic modelling sessions were facilitated by one of the researchers [JG] conducting this evaluation. The participants in these sessions were the four Consultants, and key stakeholders who were considered to have developed an informed and ongoing understanding of what the Consultants have been doing [their activities] and what they were tasked to achieve [intended outcomes]. Participants, therefore, included representation from the Scottish Government and from the host organisations [i.e. the three health boards and Alzheimer Scotland, see Appendix 1].

The output from these sessions was a logic model that reflected the consensual view of the Consultants' intended outcomes [either individually or collectively], and importantly – for which they might reasonably be held accountable. It should be acknowledged, however, that this model was developed to guide the evaluation. It was not, and is not, considered the 'definitive' model but rather 'fit for purpose'. This logic model is provided in Figure 2 [over].

Figure 2: Allied Health Professional Dementia Consultant: logic model depicting role and theory of change



2.3 Production of research tools.

The logic model was used to drive the development of interview topic guides for: [i] the interviews with the Consultants; [ii] the interviews with key stakeholders who had links to Consultants; and [iii] the online survey with AHPs.

The topic guide for the follow up interviews with AHP survey respondents was again underpinned by the logic model but more specifically drew on the survey findings, and sought to 'drill down' for further details on whether / how AHP practices had changed as a result of the Consultants' activities.[14]

2.4 Interviews with Allied Health Professional Dementia Consultants

One-to-one depth interviews were conducted with each of the Consultants on a face-to-face basis. These interviews lasted around 90 minutes and predominantly focused on what they are doing, and the changes that they have brought about, specifically in relation to the outcomes in the logic model.

2.5 Interviews with national and local strategic stakeholders

The evaluation commissioning team identified key individuals to take part in interviews. These individuals were considered to have an informed perspective on the Consultant role in general or on specific aspects of Consultants' work.

In terms of the former, these were people who held strategic, policy or leadership roles in the Scottish Government, host health boards or Alzheimer Scotland. Alzheimer Scotland Dementia Nurse Consultants were also interviewed as part of this sample.

Interviewees who were selected because of their insight into specific aspects of the Consultants' work included representation from the Care Inspectorate, Queen Margaret University and the Scottish Dementia Working Group.

While it was agreed at the evaluation's outset that the methods would not involve obtaining views of people affected by dementia, one of the interviewees was living with dementia and spoke from this perspective.

Interviews were conducted by phone and generally lasted between 20 and 45 minutes.

2.6 Survey dissemination

Members of the Alzheimer Scotland AHP Expert Group and other key contacts of the national Consultant emailed their networks with information about the survey and a link to it. All AHPs were encouraged to complete this, although the first question in the survey 'routed out' respondents who neither worked with older people generally, nor worked with people with dementia. One reminder email was sent. The survey was live for 3.5 weeks from 16 February to 10 March.

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[14] Topic guides and survey questions are available upon request from the research manager at Alzheimer Scotland.

2.7 AHP interviews

Sixteen survey respondents were selected for interview, and a total of fourteen were interviewed, all by phone. The sample was based on a number of criteria: having previously had contact with one or more of the Consultants [in order that they could provide an informed perspective]; geographical spread, including but not restricted to Glasgow, Lothian and Lanarkshire; working across a range of settings [hospital, community, care homes]; a mix of AHPs who have changed their practice and some who have not.

2.8 Analysis

The logic model provided the framework for the analysis. Thus, we sought to identify whether there was evidence to support the theory of change as presented in the logic model, and to uncover what helped or hindered effectiveness.

All relevant data were included in the analysis. Therefore, we considered what all interviewees said together with the results of the survey. The findings presented in this report are based on the range of these data sources.

While attribution of effect is problematic in an evaluation such as this, which is based on reflections/accounts of what has changed [particularly when no baseline data are available], we made concerted efforts to 'push' evaluation participants to consider whether any intended changes have been achieved *as a consequence of* what the Consultants have done. Our analysis therefore is focused on considering whether outcomes might plausibly be achieved [or already have been achieved] *as a result of the* Consultants, i.e. changes that would not have taken place [or at least to the same level] if there had been no Consultants.

Data were triangulated wherever possible. This means that, for a specific issue or research question, we considered different sources of data and sought to understand where there was agreement between these different sources. Such agreement provides more confidence in a given finding than an isolated occurrence. Where there was disparity, we considered whether this suggested that a finding was spurious, or whether the disparity could be explained: for example, a strategic stakeholder performing a management-type role might conceivably have an informed understanding of likely or actual Consultant-instigated changes to a service that may only apply to certain settings [e.g. general and acute wards] and not, as yet, have filtered down to all operational staff. Where any disparity emerges, we report this.

The findings are, of course, a distillation of what people told us – in their interviews or via the survey. Our reporting includes views about what has been positive and what has not. It is important, however, to remember that this evaluation is a modest one insofar as it was not feasible to include representation from the full range of stakeholders with whom the Consultants have engaged. Therefore, the reader should bear in mind that where evidence of [actual of perceived impact] did not emerge, omission of such detail ***cannot and should not*** be interpreted as a 'failure' of the Consultant programme. Quite simply, no evidence of effectiveness must not be confused with evidence of non-effectiveness.

2.9 Structure of the report

In the next nine chapters, we consider the emergent data 'through the lens' of the logic model. Chapter 3 focuses on the mechanism that drives the logic model, i.e. AHP Dementia Consultants perform a leadership role nationally, regionally and locally. The following chapters (Chapters 4-10) correspond to the short term outcomes that are detailed within the model.

Throughout, we look at and critique whether there is evidence to support or refute the theory of change that is explicated in the logic model. We do so by considering the accounts of the Consultants, but not by relying on these. Therefore, we present our analysis of the Consultant accounts *and then* the views of other evaluation participants. By separating these different perspectives, we are able to show whether, and (if so) where, there is triangulated evidence to suggest that the intended outcomes might [plausibly] be achieved, or indeed, where outcomes have already been achieved as a result of the Consultants. We then move on to focus on views regarding: the likelihood of changes being sustained, and in the final chapter, we consider what went well, and less well [*and why]* and the 'lessons learned'.

As previously indicated, the logic model is not a definitive [polished] version. One limitation is some level of overlap between outcomes. The implication of this is that some findings do not fit under just one heading or outcome. We therefore sometimes have had to make a decision about where to report these.

A final point to be made here is that this evaluation seeks to understand the impact of the Consultant role. It is not a performance appraisal of the four individuals involved. Therefore, the findings concentrate on the effectiveness of the Consultant role rather than seeking to differentiate between, and report on, individuals. Nevertheless, for illustrative purposes, we include some examples of work that are particular to individual Consultants.

3. Have the AHP Dementia Consultants adopted a leadership role and done so effectively?

3.1 The nature of the AHP Dementia Consultant leadership role

The Consultant role is considered to be a leadership role. To achieve the outcomes expected of the role, Consultants were required to perform a leadership role nationally, regionally and locally. The Consultants themselves endorsed this view: stating not only that they were expected to adopt a leadership role but that this was the role they performed in practice.

The nature of that leadership role involved:

- Participating in local and national partnerships, and contributing to the development and implementation of strategic policy objectives
- Advocating for greater involvement of AHPs in local decision making
- The planning and delivery of training to other AHPs – locally and in other areas of Scotland
- Developing resources for AHPs to support best practice in working with people living with dementia
- Raising awareness – both among AHPs **and** among other service providers – of the role that AHPs can play in providing post-diagnostic support to people with dementia
- Encouraging AHPs at a local level to take on greater leadership roles in their areas of influence.

3.1.1 What has helped and hindered the Consultants' leadership role?

The Consultants identified several factors that supported their efforts to exercise a leadership role in their own areas and nationally. These included:

- Substantial previous clinical experience
- Experience of working across a range of sectors as an AHP
- Having strong relationships with partners and stakeholders
- Having supportive managers, or a supportive local steering group
- Having access to high-quality coaching and leadership training.

The Consultant based in Alzheimer Scotland also identified her links with the Scottish Government and experience of national policy development as factors that supported her leadership role.

The following things were reported as hindering the leadership role of one or more of the Consultants:

- Location within the organisational structure / hierarchy
- Physical location [i.e. where the Consultants were based geographically within the board area]
- The nature of the post is one of leadership without authority.

3.2 Views of national and local strategic stakeholders and AHPs

The leadership of all of the Consultants was viewed extremely positively by the national and local strategic stakeholders. They spoke in highly praiseworthy terms of the Consultants' knowledge and expertise in championing change within their respective areas of responsibility. The Consultants' dementia knowledge and expertise, professionalism, commitment, passion and tenacity were highlighted as galvanising forces, and while the personalities and leadership styles of the individual Consultants were very different, all were seen to be highly effective in bringing about significant change in the specific domains for which they had lead responsibility. '*I think it is more the individual than the post'* observed one interviewee – a sentiment that echoed others' views that the successful leadership was due to the individuals concerned.

Example: AHP Dementia Consultant leadership in host health board

An interviewee talked of the decision to position the Consultant at an NHS board level, and to provide endorsement of her work programme through inclusion in the corporate strategic plan. This was seen as effective in not only ensuring a high profile and a platform for the Consultant, but also in enabling her to represent and lead in her area of expertise. The Consultant had presented to the Scottish Government on a couple of occasions regarding the health board's policy implementation and progress on HEAT targets. This was seen as further empowering her.

The fact that the Consultant had performed this role was indicative of the leadership that she performs.

All the Consultants were described as influential. Importantly, interviewees were in agreement that the changes that the Consultants had brought about would not have happened otherwise.

> *'She's really been quite a dynamic driving force in XXXX [host health board area], and people who know about dementia now in XXXX, you could tend to map it back to XXXX [Consultant's] involvement.' [local strategic stakeholder]*

The influence that the Consultants have had was described as extending in many directions, including upwards, e.g. to those line-managing them. There was a comment from one line manager *that, 'I wouldn't necessarily have had the same focus had she not been here'*.

Although the Consultants were credited with leading change within their respective areas of responsibility, the fact that there were four of them was seen to strengthen their influence. Furthermore, the national Consultant was considered to be a 'transformational leader influencing from the inside out' not only in terms of leadership of the AHP dementia agenda within Alzheimer Scotland, but also in terms of 'opening doors' and increasing the profile of the work of her Consultant colleagues in the territorial health boards.

It was therefore this combination of national and local Consultants which was considered to work well as a leadership model.

> *It's probably been one of the most successful models that I've seen recently in terms of the use of national spend on national leadership posts, and I think XXXX [name of national Consultant] has got to take some of the credit for that in terms of how she positioned AHPs and dementia within the Scottish Government, and her current role within Alzheimer Scotland has just been a revelation in terms of what we've actually been able to go on and achieve, and I think there's a real…and I can probably say this because I have a dementia consultant, if I didn't have one I maybe would feel very differently about this, but it has made a difference, it's definitely made a difference and we're a lot further forward than we would have been if we hadn't had our dementia consultant in post [local strategic stakeholder].*

Certainly then, there was a consensual view that the Consultants individually and collectively provided leadership. This leadership role was universally acknowledged and welcomed by the interviewees. Moreover, the Consultants were credited with progressing work that would not otherwise have happened.

Importantly, the Consultants were described as effective leaders both at a national and at the local level of the host health boards.

> *'What do you feel have been the key successes of the AHP Dementia Consultant role?' [interviewer]*
>
> *'The leadership. I think that the idea of XXXX [Consultant in local health board] …everybody knows who she is, so she has been so pro-active and one person who only really has a short amount of time to spend within this board, then she's certainly got her key message, her role, what the context of her role, what her job is, across to her team, across the whole of the city. That's one of her main successes I would say. People know who she is, people understand the agenda.' [local strategic stakeholder]*
>
> *'Can I just clarify – you said that she's been successful in getting the key message across. What would you say is that key message?' [interviewer]*
>
> *'I think the key message is that AHPs have a huge role to play in caring for people with dementia ….that they can hugely influence outcomes for patients…. and I think that's the message that she gets across.' [local strategic stakeholder]*

Notwithstanding the recognition of, and value placed on their leadership, it is important to acknowledge that this could take place within a broader multi-disciplinary and/or multi-agency approach.

Notably, there was agreement that the Consultants' leadership complemented that of the dementia nurse consultants. There was acknowledgment that '*culturally, nurses are nurses and AHPs are not nurses'*. The role of the Consultant was therefore considered to provide important leadership for the AHP professional grouping.

In addition, they were considered to exemplify and promote a holistic model of support that had ramifications across wider health and social care provision.

The interviews with AHPs with more operational roles [selected from survey respondents] provided tangible examples of the Consultant leadership percolating to their level, e.g. one AHP [in Lanarkshire] talked of the local Consultant having 'a wealth of knowledge and experience that she's been able to kind of pass down that's kind of shaped what we're doing in our own profession.' More than that, she was described as influencing the development of services, ensuring that planned changes are both realistic and person-centred.

Finally, while the Consultants' leadership was viewed extremely positively, this was caveated by a sense of realism about the scale of change that this leadership could effect:

> *'I think the reason I'm being positive is because there's only so much three or four people can do, and the three or four individuals that we've had engaged in this have done a really good job, as far as I'm concerned. … [W]e are really only scratching the surface with three AHPs! We're not really saying this is a huge, massive investment transformation, but what they've achieved with such a small investment is remarkable.' [national strategic stakeholder].*

3.3 Summary

There was consensus among national and local stakeholders that the Consultants individually and collectively had provided effective leadership in their areas of influence. This leadership role provided a platform to progress work and to lead change that would not otherwise have happened. The following section will consider how that leadership role resulted in an increased prominence and clarity of the AHP role in local and national strategies, policies and services.

4. Prominence and clarity of AHP role in local and national strategies, policies and services

The previous section examined the leadership role of the Consultants. This section considers how that role has led to clarity and changes in the prominence of AHPs in local and national dementia strategies, policies and services.

4.1 How the AHP Dementia Consultants contributed to an increased prominence of AHPs

The leadership role of the Consultants [discussed in the previous chapter] provided a basis for them to have an influence on increasing the prominence of AHPs in local and national dementia strategies, policies and services. Each of the three Consultants based in NHS Boards sought to bring about changes in this area, describing their efforts to 'be at the table' where local strategies, policies and service planning were discussed and agreed. However, this focus was a particularly significant part of the role of the Consultant based in Alzheimer Scotland. This individual had a role in contributing to Scotland's dementia strategy, and was currently leading the efforts to fulfil Commitment 4 on behalf of Alzheimer Scotland.[15]

This national policy work was seen as vital in supporting a prominent role for AHPs in the future, in relation to dementia care and support.

In addition, the Consultants pointed to several aspects of their work which demonstrated their influence in bringing about a greater prominence and clarity about the AHP role in local and national policies and services. These included:

- The establishment of and contribution to dementia strategy groups within the three host NHS board areas, and the Alzheimer Scotland AHP Expert Group
- The creation of a large cohort of AHP dementia champions linking into the existing national Dementia Champion programme.
- In Glasgow, an AHP dementia champion had been placed in an orthopaedic hospital ward to identify patients who might benefit from input from a physiotherapist or occupational therapist.

4.2 Views of national and local strategic stakeholders

Interviewees reinforced the importance of AHPs having a higher profile in local and national strategies and policies for dementia care and support. Importantly, they described the Consultants as having made progress in increasing the profile of AHPs strategically.

> *'I suppose there's been a change at policy level in terms of…how can I describe this…I suppose AHPs feature in terms of dementia care within strategy…I think that would have not happened otherwise …. So at a strategic level there has been an impact and been a change in terms of how people at that level…we are talking about the contribution of AHPs where they wouldn't have otherwise.' [national strategic stakeholder]*

[15] Commitment 4 states that Alzheimer Scotland will produce an evidence-based policy document outlining the contributions of AHPs to ensuring implementation of the 8-Pillar model. (See section 1.1 above.)

This increased prominence of the AHP role was considered to have been achieved both nationally and locally.

At a national level, this was credited, in particular, to the national Consultant: the fact that she had previously been on secondment to the Scottish Government was seen as an important contributor to this success as, at that time, she played a significant role in raising the profile of AHPs in the national dementia strategy. Building on this explicit reference to the contribution of AHPs to dementia within national policy, the Consultants were viewed as [further] increasing the prominence of AHPs strategically.

The quotations below are illustrative of the views expressed in relation to increasing AHP prominence in the national and local landscape, respectively, and then using that as a springboard to other activity.

> *'XXXX [name of national Consultant] has got to take some of the credit for that in terms of her positioning within the Scottish Government, how she positioned AHPs and dementia within the Scottish Government, and her current role within Alzheimer Scotland has just been a revelation in terms of what we've actually been able to go on and achieve.' [national strategic stakeholder]*

> *'I mean I could talk to you about commitment 4, commitment 10, commitment 11, all the kind of policy into practice, policy national work streams that XXXX [Consultant] is involved in, in terms of it brings a vibrancy to our board, that she's involved in all of those discussions, because she's so involved and she's so knowledgeable, and she's such a key part of the delivery of producing the action plan and the next set of recommendations, etc.' [local strategic stakeholder].*

Crucially then, interviewees highlighted how this increased prominence was not simply strategic rhetoric. Rather, the prominence was having an impact, by producing an enhanced understanding of the contribution that AHPs can and do bring to dementia care and support.

> *'If the Consultant wasn't there at a strategic level, the AHP voice wouldn't be heard and without that they [strategic partners] would not respect what AHPs can bring.' [local strategic stakeholder]*

The Alzheimer Scotland AHP Expert Group, convened by the national Consultant and comprising representatives of the AHP 'community' from local authorities, NHS boards and professional bodies, was considered to be an important part of the picture. Through its involvement, not only was the strategic profile of AHPs [further] promoted, greater strategic buy-in was believed to be achieved across Scotland.

> *'What XXXXX [Consultant] has managed to do is to bring the AHP community from both local authority and indeed health together into an expert group to really drive forward this type of change and improvement, and I think what we've got, we've got real engagement and we've got real commitment and we've got it from the highest level now in Government, to the frontline AHPs. We've got everyone focussed on how we can improve the interface between the AHPs and people needing their support.' [national strategic stakeholder]*

Finally, at a local level too, strategic and policy successes were often achieved in partnership, e.g. the Consultants working in partnership with Alzheimer Scotland Dementia Nurse Consultants or other stakeholders with a leadership remit. In fact, interviewees pointed to the synergy created through such inter-disciplinary collaboration.

4.3 Summary

This section has explored how the Consultants have brought about changes in the prominence of AHPs in national and local strategies. Individually, collectively and in partnership – the Consultants were seen to be succeeding in increasing the profile of AHPs' contribution at a strategic level, and this in turn has helped to create the conditions for wider and strengthened involvement of AHPs in dementia care and support. The next section looks in more detail at changes that have taken place in third sector services providing post-diagnostic support for people living with dementia and section 6 looks at changes in statutory sectors.

5. Improving linkage with Alzheimer Scotland workforce and other third sector organisations

This section examines the role of the Consultants in bringing about improvements and better links with the Alzheimer Scotland Link Workers and other third sector organisations involved in the delivery of post-diagnostic care and support.

5.1 The AHP Dementia Consultants' role in improving linkages with the third sector

The third sector, and Alzheimer Scotland, in particular, is a major provider of services to people living with dementia and their families. Thus, the third sector was an important area of focus for the Consultants, who highlighted their efforts to enhance the role of AHPs within third sector services.

Given her location within Alzheimer Scotland, the national Consultant played a key role in this respect. This individual considered that a significant part of her work involved raising awareness, both among Link Workers and among people living with dementia and their families, of the contribution that allied health professions can make to post-diagnostic support.

Two of the other Consultants also spoke about their efforts to facilitate the connections between Link Workers and AHPs, and some successes were highlighted. For example, in one health board area:

- AHPs were becoming involved in attending dementia cafes
- AHPs and Link Workers were planning and running joint sessions for people living with dementia
- AHPs were now taking referrals directly from Link Workers.

Another Consultant referred to work that she had undertaken together with a colleague from Alzheimer Scotland to provide dementia awareness training to firefighters in another health board. This Consultant was also involved in delivering lectures to occupational therapy students at a local university, in which she introduced students to new ways of working in partnership with the third sector, using asset-based approaches to providing support to people living with dementia.

The Consultants highlighted three factors that had supported their work in this area:

- Strong support from the highest levels (including from the CEO) of Alzheimer Scotland
- The HEAT target on improving post-diagnostic support (mentioned in Chapter 1) which requires all people newly diagnosed with dementia to have a minimum of one year of post-diagnostic support coordinated by a Link Worker and a person-centred support plan
- The fact that many of the Link Workers have a background working as AHPs. Although it was pointed out that these individuals are not currently working as AHPs in their role as Link Workers, they nevertheless have a good understanding of what an AHP can contribute to supporting a person living with dementia, and so the Link Workers have largely been receptive to working alongside AHPs.

5.2 Views of national and local strategic stakeholders

The profile of Alzheimer Scotland was believed to be promoted and indeed heightened through the Consultant programme. This was described as being a development that was highly functional as it enhanced the [effective] implementation of the dementia strategy.

> *'[The Consultant] navigated a very successful connection between previous colleagues in Scottish Government and colleagues, in particular the Chief Executive, of Alzheimer Scotland, in helping to realise the aspirations of the dementia strategy…' [national strategic stakeholder]*

Stronger alliances across statutory and third sector organisations were perceived to have been established and sustained with:

> *'….. all the stakeholders, not just the AHP directors and consultants and practitioners, but also the vast network of dementia resource people and centres and the support systems that are available to people, and the wider connections with places like the Care Inspectorate and the work of care homes, other organisations like Age Scotland, etc. ' [national strategic stakeholder]*

The Chief Executive of Alzheimer Scotland was identified as being enormously supportive and a key factor in these successes.

> *'The act of engagement of the Chief Executive in the evolution of the role has, with that sort of tacit support – explicit and open support of XXXX's [the national Consultant] contribution, has opened doors for her and has allowed some of those synergies and strategic alliances to evolve.' [national strategic stakeholder]*

A 'fairly meaningful relationship' was said to have been established between Alzheimer Scotland and Queen Margaret University. This had arisen from ongoing links between two of the Consultants and the University which have involved lectures and module development and subsequently led to increasing undergraduate and postgraduate AHP capabilities in relation to dementia. [More details about this are provided in Chapter 7.] In addition, Alzheimer Scotland is funding an AHP Doctoral Training Programme [due to start in September 2015] focusing on the role of the occupational therapist and use of the Tailored Activity Programme [TAP] in caring for people living with dementia.

A strategic alliance is expected to be ratified between Queen Margaret University and Alzheimer Scotland, with plans for this to be formally 'signed off' in April 2015. It is assumed therefore that this indicates a commitment to *sustained* [two way] links.

It should be acknowledged here that there is also Consultant involvement with other universities, but as this evaluation did not include informants from these latter institutions, we are unable to provide [triangulated] evidence about whether staff members at these could testify to improved linkages with Alzheimer Scotland.

Alzheimer Scotland also offers AHP student placements and employs some AHPs within the organisation, e.g. dementia Link Workers and dementia advisors. This was described as creating a new and good opportunity for AHPs to move from the NHS to the third sector.

'Another area that I think has been important, and one that I would be particularly keen to see evolve is the development of placements for and internships for AHPs interested in working in third sector settings. So that is about changing or shifting people's preconceptions about where the exciting places to work are.' [national strategic stakeholder]

For one of the health board areas, an enormous amount of multi-agency activity was described – both through the Consultant's role in developing a highly acclaimed dementia friendly community [and subsequent expansion and roll-out] and also her wider reach to a host of organisations within the health board area, including many non-statutory ones, e.g. local shops and stores, religious groups and organisations, and 'volunteers' involved in supporting people living with dementia. The contribution that this work has made to other outcomes will be explored further in Chapter 6.

5.3 Views of AHPs

The interviews with AHPs [selected from among the respondents to our online survey] also provided examples of strengthened links with the third sector, e.g. one AHP talked of her contact with the Consultant leading her to engage in more partnership working with the voluntary sector in her development of training for carers [in Fife].

5.4 Summary

This section has discussed the impact of the Consultant role on bringing about closer links between AHPs and third sector services – particularly Alzheimer Scotland, but also other services in the third sector. Evaluation participants highlighted evidence of increased joint working between AHPs and Link Workers, and of strengthening relationships between the third sector and the universities involved in AHP education. The important role of Alzheimer Scotland in supporting this work was seen as a factor that had contributed to the success of this work.

While this chapter has examined the Consultants' role in bringing about improved links with third sector service providers, the next chapter will consider how they have contributed to an increased understanding of the role of AHPs in services more widely.

6. Increasing understanding of the role/contribution of AHPs among statutory and non-statutory services

This section will consider the impact of work undertaken by the Consultants to bring about an increased understanding within wider NHS, local authority and private sector care home services [as well as third sector services] of the role and contribution of AHPs in dementia care and support.

6.1 The AHP Dementia Consultant role in increasing understanding within services

The Consultants commented that there are significant cultural barriers within services [particularly acute hospital services] to involving AHPs at an early stage in the care of people with dementia. These barriers were thought to be at least partly related to the fact that, traditionally, AHPs have been difficult to access because there are so few of them.

Thus, a significant aspect of the work for some of the Consultants was about making connections with people and highlighting the ways in which AHPs can be more involved *at an earlier stage,* in working with people with dementia across a range of settings. There were two parts to this work: the first involved raising awareness [usually] among health colleagues [particularly doctors and nurses] about the contribution that AHPs can make, and the second involved raising awareness among AHPs working in statutory and non-statutory services about the contributions that they themselves can make.

The national Consultant considered that much of communications activity taken forward by the Consultants [i.e. producing national publications, speaking / presenting at conferences and workshops, publishing papers, co-ordinating the on-line blog, and the AHPproaches newsletter] all had a role in raising awareness, both among AHPs, but also among other services, about the role and contribution of AHPs in relation to working with people with dementia.

The Consultants also highlighted strands of their work that have involved exploring how hospital-based AHPs can support people living with dementia to get back home from hospital earlier (i.e. to avoid delayed discharges), and working with radiographers to raise awareness of how they can work more effectively with people with dementia.

The Consultants suggested that the evidence of this increased understanding was that AHPs were beginning to adopt new approaches, and services were beginning to change the way they do things by involving AHPs earlier in the care of people diagnosed with dementia. For example, in one health board area, an AHP dementia champion had been placed in an orthopaedic hospital ward to identify patients who might benefit from input from a physiotherapist or occupational therapist and, as noted in Chapter 5, in another health board, Link Workers are now making referrals directly to AHPs. The overall impact of the Consultants' awareness-raising activity will be discussed further in Chapter 8 in relation to AHPs learning of new approaches for supporting people living with dementia.

6.2 Views of national and local strategic stakeholders

There was a commonly articulated view that the context in which the Consultants were working, certainly at the outset, was one in which AHPs' potential was not fully realised.

'I think they were hidden under a cloak, nobody knew exactly what they were.' [local strategic stakeholder]

Interviewees talked about the importance of improving understanding of the contribution that AHPs can and do make to dementia care and support.

'*What I would say is that there's a very, very strong but very hidden demand there for these skill sets. ….I think that they [AHPs] have got a really nice balanced skill set that we need to push forward there.' [national strategic stakeholder]*

They highlighted that services [and indeed the public at large] currently do not always recognise what AHPs can and do offer. Thus, there was insufficient demand for AHPs in dementia care and it was thought that demand should be increased.

' … it's a lack of understanding about what the role would be. …. So part of [the Consultant] role is about raising awareness about - it's not just about nursing having a hugely important role to play, but there are also these other different disciplines and they can help with these specific things.' [national strategic stakeholder]

In fact, there was a view that, to promote the role of AHPs requires the articulation of the 'added value' of AHP involvement. Without this, it was felt, there was a danger that nurses, in particular dementia nurses, would be considered as *the* [singular] solution to dementia care and support.

Increasing understanding by service providers of the potential and actual contributions of AHPs to dementia was seen to include reaching AHPs themselves. In this respect, there was a lot of support for the notion that the Consultants, individually and collectively, have succeeded in increasing understanding of what AHPs can and do contribute.

'We're helping turn the tanker if you like, a community that was a bit disconnected, yet dealing with lots of people with dementia in hospitals, and in the community and the local authorities who were a bit disconnected from the national dementia strategies; we've now brought them together and they've got a real focus of what their skill set can do to improve the lives of people with dementia.' [national strategic stakeholder]

Changes within the acute sector were highlighted. One strategic stakeholder considered the recent changes among AHPs working in the acute sector to be so marked that it was a 'paradigm shift' and that lack of understanding among AHPs was 'a thing of the past'.

The extract below indicates that changes were considered to go beyond simply better understanding, but extended to changed practice, and ultimately improved outcomes for people living with dementia.

'So where do you think they're able to demonstrate their effectiveness in achieving outcomes?' [interviewer]

'I think through some of the work in the acute hospitals around some of the improved discharging. I would suggest that there is less re-admission for people with dementia, there's more knowledge around what the resources are out in the community to support people around the education and training, around promoting excellence, it would definitely be a win-win for them all. I'm absolutely confident of that.' [National strategic stakeholder]

Triangulated evidence on AHPs' increased understanding of their role in one health board area

The extracts are illustrative of the range of accounts testifying to the enhanced understanding of the AHP role that has been developed through the work of one Consultant based in an NHS board.

'We have an issue, not just in NHS XXX, but in AHPs – where the AHPs who work within mental health services have grasped the sort of general health agenda of their population, so round about physical exercise, diabetes, nutrition and all that sort of stuff, and that's not been replicated the other way, so within the body of staff, the knowledge about people with mental health issues, dementia etc., probably wasn't as prominent until XXXX came along.' [local stakeholder]

'I think also by bringing all the different AHPs together XXX [Consultant] helped increase the knowledge of the other AHPs' role within dementia and how we can refer it into different services and what's available for different people'. [AHP]

6.3 Views of AHPs

Evidence from the survey of AHPs strongly supported the notion that among *individuals*, there was a greater appreciation of the potential contribution that AHPs can make in dementia care and support. Furthermore, some made references to now being aware of the dementia strategy and the 5 and 8 pillar models. The responses below are illustrative of the changes that individual AHPs say have happened *because of* their contact with Consultants.

'They have helped me to focus on the priorities for AHPs in dementia care and take these forward.'

'It has encouraged me to make dementia at the forefront of my thinking and to re-evaluate my practice.'

'…recognising the role of dietitian in management of people with dementia'

These comments were also echoed in the interviews with AHPs. This group emphasised that, at a local level, other professionals were beginning to see the advantages of having AHP input in working with people with dementia.

'I think they've [the Consultants] helped our profile, and I think there's a real recognition from other professionals that …there's a real benefit from having us involved in things, so I think there's a bit more recognition [among other services] that we're there and what we can offer.' [occupational therapist]

Example: beyond understanding to changed AHP practice in host NHS board

A local strategic stakeholder in one of the host health boards spoke of the 'risk tool' developed by one Consultant. This was developed within the context of, and to address, risk- averse practice, and to prevent [unnecessary] hospital admission and to encourage earlier hospital discharge for individuals with dementia. This interviewee talked of occupational therapists and physiotherapists working together in the medical assistance unit, so that when a patient is admitted there for assessment [and with a view to admission as an inpatient] – 'all stops will be pulled out' to ensure that these patients go home if they are fit to do so. This was described as a 'huge turnaround.'

This example provides support not only for the short-term outcome of increased understanding, but importantly, the contribution that this makes to greater and more timely AHP involvement in dementia care and support – a medium term outcome in the logic model.

6.4 Summary

This section has discussed the role that the Consultants have played in bringing about a deeper understanding – within services and within AHPs themselves – of how AHPs can contribute to the care and support of people living with dementia. The focus has been on trying to get AHPs involved at an *earlier* stage in a person's care. Evidence was highlighted from a range of sources that shows that AHPs are beginning to understand this role, and that services (particularly acute services) are also beginning to recognise the benefits of involving AHPs earlier.

In Chapters 7 and 8, we present findings to show how the impact of the increased understanding by AHPs has led to AHPs learning and becoming enthused about new approaches for working with people living with dementia.

7. Training for AHP workforce is increasingly focused on best practice

In this chapter, we report findings regarding the Consultants' influence on the training of AHPs.

7.1 The role of the AHP Dementia Consultants in training the AHP workforce

Training and up-skilling the current AHP workforce was reported to be a substantial part of the role of the Consultants based in the three NHS Boards. These three individuals contributed to the delivery of the *Promoting Excellence* framework for health and social services staff working with people affected by dementia.[16] They have particularly been involved in training other trainers [i.e. training AHPs to deliver training to other AHPs at a local level], thus contributing to the memorandum of understanding of having 75% of all AHPs trained to "skilled" level.

The fourth Consultant focused primarily on the training of the future AHP workforce in undergraduate and postgraduate tertiary education [ensuring that all new AHP graduates have attained the "skilled" level from the *Promoting Excellence* framework]. This has included the development of student placements and internships within Alzheimer Scotland, as well as potential volunteer opportunities. Initially, this initiative was developed in partnership with Queen Margaret University, but efforts are currently ongoing to expand it to other Scottish universities involved in training AHPs.

The Consultant in one NHS Board has particularly been involved in the delivery of bespoke training and support in relation to TAP [Tailored Activity Programme] to other AHPs. TAP was described as 'an innovative, best-practice approach' to assessing the capabilities of a person with dementia, and tailoring a programme of support for their specific situation. The use of TAP had been formally piloted and evaluated in two areas, and was also in the process of being introduced to occupational therapists in Ayrshire, Dumfries and Highland.

The Consultants have also:

- Supported AHPs to make use of research and best evidence in their practice with people with dementia
- Supported and promoted Alzheimer Scotland's dementia champion programme by identifying and encouraging AHPs to apply for training as dementia champions
- Delivered dementia awareness training to a wide range of staff groups, carers and members of the public
- Contributed to in-service training and other forms of training for specific AHP groups.

The task of training also included, more broadly, the creation and facilitation of networks and forums for AHPs to share experiences and good practice with each other.

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[16] The *Promoting Excellence* framework, referred to earlier in Chapter 1, was developed by NHS Education for Scotland and the Scottish Social Services Council. It defines four levels of knowledge and skills in relation to working with people with dementia. These are: Informed, Skilled, Enhanced and Expertise. The "Skilled" level is intended for all health and social care staff who have direct face-to-face contact with a person affected by dementia. See http://www.gov.scot/resource/doc/350174/0117211.pdf.

The Consultants considered that their various contributions to training and up-skilling of other AHPs were among their greatest and most sustainable impacts.

7.2 Views of national and local strategic stakeholders and AHPs

In Chapter 5, we began to highlight the work that Consultants have progressed with universities, particularly the Queen Margaret University [QMU] – described as one of Scotland's 'biggest AHP educators'.

This has included a study day with over 200 OTs which was subsequently developed and extended into a couple of modules for undergraduates and a new postgraduate module for qualified AHPs. These are scheduled to run from September 2015. These modules will be optional 'until we see how it goes' – a perspective that implies that a possibility that these might subsequently become a mandatory part of training there.

The interviewee from QMU acknowledged that the whole topic and study of dementia, dementia services and dementia care has been raised considerably within QMU, and that this would not have happened, at last not to the same level, had there not been Consultant involvement. Moreover, there was a sense the Consultant involvement not only increased information on dementia, but provided additional knowledge and insights on the implementation of strategies, policies and interventions; in other words, it was focused on relevant and current issues in dementia.

The changes that have been brought about at QMU were described as transformative for future AHPs.

Stakeholders in local NHS Boards also emphasised the important part the Consultants have played in training the existing AHP workforce. *Promoting Excellence* is a key vehicle for upskilling the health and social care workforce, including AHPs. The Consultants were described by the strategic stakeholders as performing a pivotal role in delivering this training. In addition, there were descriptions of the training being informed by Consultant input, e.g. a national stakeholders talked of a Consultant running a focus group to identify AHP needs, of these shaping aspects of the training, of then achieving a high level of training to the whole profession [with over 1000 AHPs trained at 'informed' and 'skilled' level] and afterwards supporting AHPs via masterclasses 'to make sure that everyone was reflecting on their practice'.

An example: a multi-level approach to training in a host NHS Board

In one of the host health boards, the Consultant was described as being the corporate team lead for improving and increasing dementia awareness training. Her performance in relation to *Promoting Excellence* was viewed as impressive, particularly in view of the scale of the task and the timescale for delivery: it was estimated that she had trained 90% of its 1800 staff, including all of its AHP professions. This was seen as having 'made a huge impact' for the board.

It was considered that 'transference of strategy and policy into practice' was achieved

through her mentoring of AHP dementia champions whom she had brought together 'as a cohort group'. While these dementia champions were considered to be 'a vibrant group' [who contributed lots of posters at its most recent annual AHP conference], it was suggested that the Consultant 'has to take some of credit for keeping them going, helping them, supporting them, and offering advice to them in their own clinical areas in terms of the work they have actually taken forward'.

The Consultant has led a national pilot of the Tailored Activity Programme [an intervention that aims to help carers to support the person with dementia to continue to engage in meaningful and enjoyable activities using their remaining abilities and compensating for the difficulties caused by their dementia]. This was described as providing new evidence [on what works], as 'a real game changer', particularly for occupational therapists [OTs] and as a 'big asset to Scotland'. The national reach of the Consultant's communications around the TAP [by conference presentations, networking, blogging and other forms of social media] were described as 'quite incredible.' There was some support for this training not only being nationally delivered but also applied e.g. one of the AHPs we interviewed [in Ayrshire and Arran] talked of now being trained in TAP and now using it in her own practice.

Findings from the AHPs also indicated that the Consultant had delivering training on the Allen Cognitive Level Screen. Mention was made of the fact that her training has resulted in 50 OTs now trained in the assessment across the Ayrshire and Arran board area.

7.3 Summary

This chapter has discussed the role of the Consultants in influencing and delivering training to the current – and future – AHP workforce. This aspect of their work was considered to be wide reaching and highly effective. The next chapter will explore the impacts on knowledge, skills and practice which have resulted from the training of AHPs.

8. AHPs learn of, and are enthused by, new approaches

Chapters 4-6 of this report have largely focused on the Consultants' influence on strategic and/or service changes. Chapter 7 represented a shift in focus, towards the Consultants' influence on and contribution to changes in training for AHP workforce. This chapter considers the evidence for changes in knowledge, skills and practice within the AHP workforce resulting from the Consultants' efforts.

This chapter presents AHP's **own** views on whether they have developed insights and learned new ways of working, the relevance of these to their jobs, and their interest / enthusiasm in these. Thus, the findings reported here are based on responses from the survey and interviews with AHPs.

8.1 The Consultants' role in helping AHPs to learn of and be enthused by new approaches

In addition to their roles in the co-ordination, development and delivery of training [discussed in Chapter 7], the Consultants also produced a range of publications and resources to inform AHPs about new, innovative and evidence-based approaches to working with people with dementia. Thus, while these publications had an important awareness-raising function – their content focused specifically on best practice interventions and approaches.

The key publications and resources discussed as part of this evaluation were:

- The National AHPs Best Practice in Dementia Network website [referred to as: the AHP Dementia Community of Practice] [commenced 2011]
- Three national publications:
    - *Allied Health Professionals Dementia Champions: Agents of Change [August 2014]*
    - *Allied Health Professionals Delivering Post-Diagnostic Support: Living Well with Dementia [September 2014]*
    - *Allied Health Professionals Delivering Integrated Dementia Care: Living Well with Community Support [December 2014]*
- The on-line blog site: "Let's Talk about Dementia" [commenced June 2014]
- The quarterly electronic newsletter: *Dementia AHPproaches* [commenced 2011]
- The leaflet: *Make Every Moment Count* [completed 2012, launched February 2013]

The co-ordination of the Alzheimer Scotland AHP Expert Group in Dementia was also highlighted as an activity that involved introducing innovative best practice to AHP leaders throughout Scotland – with the intention that those individuals would be able to disseminate those practices more widely within their spheres of influence.

8.2 Views of AHPs

As part of this evaluation, a national survey was carried out among AHPs. The survey asked about people's awareness of the publications and resources produced by the Consultants [i.e. those listed in section 8.1 above], and the relevance of those publications / resources. It

also asked respondents to indicate whether, in the last 24 months, they had: [i] learned about any new approaches for working with people with dementia, [ii] whether they found those approaches relevant, and [iii] the extent to which they had been able to incorporate those approaches into their own practice. Finally, survey respondents were asked if they had had any contact with any of the four Consultants and if so, what the nature of the contact was.

8.2.1 About the survey respondents

Altogether, 385 individuals took part in the survey. Occupational therapists comprised the largest group of AHPs within the survey sample [44% of respondents were OTs]. Physiotherapists and speech and language therapists comprised the next two largest groups [20% and 11% of respondents respectively]. Most respondents [92%] were employed by the NHS and 60% worked in community settings. A small proportion [7%] were dementia champions. Appendix 2, section A2.1 provides further details about the survey respondents.

8.2.2 Awareness of publications and resources

In general, survey respondents had relatively low awareness of the various publications and resources produced by the Consultants. [See Tables 8.1 and 8.2 below.] The proportion who said they had NOT seen individual resources ranged from 37%-58%. Similarly, in general, fewer than 25% of respondents said they had used the resources frequently or regularly, or had read most or all of a particular publication. The exception to this was in relation to the leaflet, *Make Every Moment Count.* Just over a third of respondents [35%] said they had read most or all of this leaflet. However, this may be related to the relatively small response rate on the question about that publication as compared with other questions. In addition, as noted in section 8.1 above, *Make Every Moment Count* was published earlier than all of the other documents in Table 8.1.

Table 8.1: To what extent are you familiar with….

	I have not previously seen this	I have seen this but have not read it	I have read some, but not much of this	I have read most / all of this	Total
Allied Health Professionals Dementia Champions: Agents of Change	141 [39%]	69 [19%]	76 [21%]	78 [21%]	364 [100%]
Allied Health Professionals Delivering Post-Diagnostic Support: Living Well with Dementia	164 [45%]	73 [20%]	53 [15%]	72 [20%]	362 [100%]
Allied Health Professionals Delivering Integrated Dementia Care: Living Well with Community Support	209 [58%]	59 [16%]	43 [12%]	48 [13%]	359 [100%]
Make Every Moment Count	58 [37%]	20 [13%]	24 [15%]	56 [35%]	158 [100%]

Table 8.2: To what extent are you familiar with….

	I have not seen this website / blog / newsletter	I have seen this but have not used / read it	I seldom read this	I sometimes / occasionally read / use this	I use / read this frequently	Total
National AHPs Best Practice in Dementia Network website [the AHP Dementia Community of Practice]	134 [37%]	114 [31%]	N/A	97 [27%]	21 [6%]	366 [100%]
On-line blog: "Let's Talk about Dementia"	207 [58%]	56 [16%]	19 [5%]	54 [15%]	24 [7%]	360 [100%]
Quarterly electronic newsletter, *Dementia AHPproaches*	176 [49%]	25 [7%]	18 [5%]	62 [17%]	78 [22%]	359 [100%]

There was some variation in awareness across NHS Boards. Furthermore, the greatest levels of awareness were not necessarily in the three NHS Boards where the Consultants were based [i.e. Lothian, Lanarkshire and Glasgow]. The following three examples illustrate this point.

- Overall, 32% of respondents said they had used the AHP Dementia Community of Practice website **occasionally or frequently**. However, more than 40% of respondents in Fife [41%], Lothian [45%], three NHS Boards in the south of Scotland [47%], Highland [50%] and Lanarkshire [51%] said they had used this website occasionally or frequently.[17] On the other hand, in Greater Glasgow & Clyde, only 18% of respondents said they had used the website occasionally or frequently.

- Overall, 50% of respondents said they had read at least **some** [i.e. some, most, or all] of the leaflet, *Making Every Moment Count.* However, 70% of respondents from Fife had read at least some of this leaflet, along with 60% of respondents from Lanarkshire.

- Overall, 35% of respondents said they had read at least **some** [some, most, or all] of the publication *Allied Health Professionals Delivering Post-Diagnostic Support: Living Well with Dementia.* However, between 47-69% of respondents in Lothian, Highland, Lanarkshire, the South Scotland Boards and Fife had read at least some of this publication. In relation to this publication, lack of awareness was greatest [i.e. people had not previously seen the publication] in the Island Boards, Grampian and Greater Glasgow & Clyde.

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[17] Throughout this section, the South Scotland Boards refer to NHS Borders, NHS Dumfries & Galloway and NHS Ayrshire & Arran. The Island Boards refer to NHS Western Isles, NHS Orkney and NHS Shetland. These six boards have been grouped together into two categories because of the small number of responses from each of them individually.

Similarly, there was also considerable variation in levels of awareness of the publications / resources among different AHP professional groups. In general, occupational therapists had the highest levels of awareness [i.e. the largest proportion who had read most or all of the different publications, and who regularly used the newsletter or the Community of Practice website]. However, there were some exceptions. For example:

- While 35% of respondents overall said they had read **most or all** of the leaflet, *Making Every Moment Count,* 42% of the dieticians who took part in the survey said they had read most or all of it – along with 42% of occupational therapists.
- While 42% of respondents overall said they had read at least **some** of the publication, *Allied Health Professionals Dementia Champions: Agents of Change,* 61% of the speech and language therapists who took part in the survey said they had read at least some of this publication – along with 52% of occupational therapists.

Full details of the survey findings in relation to the awareness of publications is given in Appendix 2, section A2.2.

8.2.3 Views about the relevance of the publications

If respondents to the survey indicated that they were familiar with a particular publication or resource, they were asked a follow-up question about whether they had found it useful / relevant.

Overall, the publications and resources produced by the Consultants **were** considered to be relevant and useful among those who had read them. Individual publications were rated as 'very useful / relevant' by between 46% - 64% of respondents. In contrast, no publication was described as 'not useful / relevant' by more than 6% of respondents, and in fact, all but one of the publications were given that rating by only 2-3% of respondents.

See Appendix 2, section A2.3 for details.

8.2.4 AHP's views about the impact of the Consultants on their knowledge, skills and practice

Finally, respondents were asked several questions about changes in their knowledge, skills and practice. Specifically, they were asked if they had learned about any new approaches for working with people with dementia in the last 24 months; the extent to which those new approaches were useful / relevant to them in their job; and the extent to which they had been able to incorporate those new approaches into their own practice with people with dementia. Respondents were also asked whether they had ever had any contact with the Consultants [by email, face-to-face or in a group context].

Just over two-thirds [68%] of respondents said they had learned about one or more new approaches for working with people with dementia in the last 24 months. Of these, nearly all [99%] said that these new approaches were somewhat or very useful / relevant, and 90% said they now used these new approaches in their own practice [either sometimes or regularly].

In their comments, respondents frequently referred to the *Promoting Excellence* training, the dementia champion training, TAP [Tailored Activity Programme], university courses, the 5 pillars of post-diagnostic support, the [Large] Allen Cognitive Level Screen, the Making Every Moment Count DVD, and the 'Butterfly scheme' – among other things.

Interestingly, the survey findings also clearly showed that respondents who had had some form of contact with the Consultants were **more** likely than other respondents to say that they had: [i] learned about new approaches in the last 24 months; [ii] had found those approaches **very** useful / relevant to their work; and [ii] had incorporated those approaches **regularly** into their own practice. See Tables 8.3, 8.4 and 8.5 below.

Table 8.3: In the last 24 months, have you learned about any new approaches for working with people with dementia?

Have you had any contact with any of the AHP Dementia Consultants?	Yes, I have learned new approaches	No, I have not learned new approaches	Total
Yes, has had contact with Consultants	**123 [85%]**	22 [15%]	145 [100%]
No, hasn't had contact with Consultants	99 [54%]	86 [46%]	185 [100%]
Not sure / don't know if has had contact	18 [72%]	7 [28%]	25 [100%]
Total	240 [68%]	115 [32%]	355 [100%]

Table 8.4: To what extent did you feel that these new approaches were useful / relevant to you in your job?

Have you had any contact with any of the AHP Dementia Consultants?	Not at all useful / relevant	Somewhat useful / relevant	Very useful / relevant	Total
Yes, has had contact with Consultants	-- [0%]	36 [29%]	**87 [71%]**	123 [100%]
No, hasn't had contact with Consultants	2 [2%]	51 [50%]	48 [48%]	101 [100%]
Not sure / don't know if has had contact	-- [0%]	6 [33%]	12 [67%]	18 [100%]
Total	2 [1%]	93 [38%]	147 [61%]	242 [100%]

Table 8.5: To what extent do you feel you have been able to incorporate these new approaches [or a new approach] into your own practice with people with dementia?

Have you had any contact with any of the AHP Dementia Consultants?	I have not been able to incorporate this approach [these approaches] into my own practice	I sometimes use this approach [these approaches] in my own practice	I now use this approach [these approaches] regularly in my own practice	Total
Yes, has had contact with Consultants	12 [10%]	57 [46%]	**54 [44%]**	123 [100%]
No, hasn't had contact with Consultants	12 [12%]	60 [60%]	28 [28%]	100 [100%]
Not sure / don't know if has had contact	1 [6%]	13 [72%]	4 [22%]	18 [100%]
Total	25 [10%]	130 [54%]	86 [36%]	241 [100%]

When asked about the nature of their contact with the Consultants, the comments made by respondents fell into five main themes:

- Respondents met the Consultants at workshops, seminars, or conferences where they were speaking or presenting, or through networks and forums of AHPs [which the Consultants had sometimes created].
- Respondents had contacts with Consultants through training [including training that the Consultants had developed or were delivering].
- Respondents had approached the Consultants for advice or support in relation to working with people with dementia, and these relationships were often described as still ongoing.
- Respondents had been contacted by Consultants through emails or other dissemination or awareness-raising activities.
- Respondents had participated in the TAP project, or were in the process of receiving training, advice or support related to TAP.

In their comments, respondents to the survey often described the Consultants as 'inspiring', 'passionate' and 'enthusiastic'.

8.2.5 Further exploration of impact on knowledge, skills and practice

A total of 14 survey respondents took part in short telephone interviews to explore in further depth the impact of the work of the Consultants on their knowledge, skills and practice. All of those chosen for interview had indicated in their survey responses that they had had previous contact with one or more of the Consultants.

The following quotes illustrate the range of impacts identified by those who were interviewed:

- **Changes in knowledge among AHPs**

"I think also by bringing all the different AHPs together she's helped increase the knowledge of the other AHP's role within dementia and how we can refer it into different services and what's available for different people." [Speech and language therapist]

"I'd been introduced to the 8 pillars at a conference, and … I think that really helped me to define really what my role was, you know, I know some people in some areas think 'OTs are doing that' or 'Alzheimer Scotland are doing that' and 'Who's role is what?', 'They're providing support' or 'They're doing this' and 'Should I be doing that?' … I found that again, with the help of the AHP consultant, I came away, I think, very clear about what my role was as an OT." [Occupational therapist]

- **Changes in skills among AHPs**

"I suppose the contact with the AHP Dementia Consultants…has increased my skillset. I'm now trained in the tailored activity programme approach, which just a small number of OTs are across Scotland. I use parts of the programme, so from that point of view, that's been really good for my own professional development.

The assessment that I was talking about a minute ago, which was the large Allen Cognitive Level Screen…is an assessment that I use really frequently, and I was so impressed with it that I asked [Consultant] to do some training within [NHS Board] and now we've got about 50 OTs trained in the assessment across the whole health board." [Occupational therapist]

"I certainly think she's facilitated quite a lot of the promoting excellence training and helped us disseminate that to the whole profession, so she's been quite involved in that, so not just my own knowledge and skills but being able to pass it on to the rest of my team." [Speech and language therapist]

- **Changes in practice among AHPs**

"We're using the principles of the TAP within our wards. We've got … the kind of longer stay wards with people with maybe more challenging behaviours who are maybe awaiting nursing home places or who are unable to go to nursing homes because of their behaviour at the moment. And we've been using the principles of [TAP] within the ward. The principles have helped us just to have a different interaction with those patients that we were maybe struggling with knowing what to do with or how to support before." [Occupational therapist]

"So that's had an impact on the practice with day to day working with patients in terms of how I speak with patients, communicate with patients. I think in terms of the words that are used around dementia and people with dementia, things like that, living with dementia, all these kind of positive words being attached to it." [Dietician]

Those who took part in the interviews were largely very positive in their perceptions of the work of the Consultants, describing them as 'absolutely brilliant', 'very approachable', 'a big support', and 'really knowledgeable'.

However, one interviewee, an occupational therapist, was less positive in her views. This individual perceived that the Consultants were too remote from the day-to-day activities of AHPs to be able to influence practice, and also saw an inconsistency between the messages promoted by the Consultants and her own experience of post-diagnostic support.

"I don't think OTs are leading post-diagnostic support. I think the employed link workers are, and I noticed that there was quite a fancy paper, a fancy booklet about AHPs and what we're doing for post-diagnostic support. I think in a supervisory capacity, it sits very well with OT in terms of philosophical backgrounds and obviously looking at the 5 pillars, very good, but in terms of OT and post-diagnostic support, we're really not there. We're really not…. I see them based at more of a strategic level, where the information doesn't filter down to OTs working at the coalface with dementia. They don't ask us any questions, they don't ask for our feedback, they're only strategic, and that's such a shame because I was really excited about the posts because I would be looking to them for their expert knowledge…" [Occupational therapist]

Two other interviewees, a physiotherapist and a podiatrist, were more measured in their views, suggesting that perhaps the Consultants had had less contact with certain staff groups.

> *"I would say possibly no [AHP dementia consultant had not increased AHP involvement in dementia care and support], just from my other colleagues that aren't doing that…yeah I would possibly say there's not been much sort of roll out within…on the ground as it were with the rest of the team. I mean I think I only know about it through my member of staff who knows about it type of thing, so I don't think it's kind of…widespread change in service or anything like that." [Podiatrist]*

> *"I think they've achieved it very well in publicising and sharing and promoting AHPs in general in dementia care. I would say as a physio, and this probably is partly my ignorance, but there hasn't been enough specific to physio to develop our game with dementia. The AHP consultants, I think there's three in Scotland, I think possibly they're all OT backgrounds and to my knowledge none of them are physios…." [Physiotherapist]*

8.3 Summary

This section has presented the findings from the survey and interviews with AHPs. It has focused on how the work of the Consultants has resulted in AHPs learning, and being enthused, about new approaches to working with people with dementia. The findings of the survey suggest that although the reach of the Consultants among the wider AHP workforce has been somewhat limited, their impact among those they *have* reached has been substantial. AHPs gave numerous examples of how their knowledge, skills and practice had changed as a result of their contact with the Consultants. It is particularly notable that AHPs who reported some form of contact with the Consultants were **more** likely than those who did not, to say that they had: [i] learned about new approaches in the last 24 months; [ii] had found those approaches very useful / relevant to their work; and [ii] had incorporated those approaches regularly into their own practice.

The next chapter considers the impact of the Consultants on increasing awareness of organisations and services regarding tailoring requirements to meet the needs of people with dementia.

9. Increased awareness among organisations and services regarding tailoring requirements to meet needs of people with dementia

This section considers the ways in which the Consultants have influenced the understanding of service providers and a wider range of organisations and agencies about how they can be more 'dementia aware' and what they can or should *do* in order to better support people living with dementia.

9.1 Raising awareness among organisations and services about tailoring requirements

The Consultants commented that a significant aspect of their work was about 'making dementia everyone's business'. While all of the activities undertaken by the Consultants could be viewed as promoting this idea, in this chapter the focus is on organisations and settings 'in the community'. Importantly, the Consultants highlighted that the task of 'making dementia everyone's business' can only be achieved through partnership working.

The work of one of the Consultants was particularly focused on working with community partners to raise awareness of how they could, more effectively, support the needs of people living with dementia by making small changes in the way they communicated and dealt with people. This work resulted in Motherwell becoming Scotland's first dementia-friendly town centre.

A second Consultant also spoke of her efforts to support local community services to better understand the needs of people living with dementia. In particular, a project was being developed with leisure centres and a 'falls co-ordinator' to deliver exercise classes to older people to reduce their risk of falls. The Consultant's role was to work together with the leisure centres to develop a short training session for leisure centre staff (i.e. receptionists, cleaners, trainers) to raise awareness of how they can best offer support to people with dementia who may be attending the exercise classes.

9.2 Views of national and local strategic stakeholders

The work around establishing dementia friendly communities was highlighted as in important development, and the Consultant responsible for this was credited for her 'tremendous' / 'marvelous' work in this respect. One national stakeholder commented:

> *'[The Consultant] has done a tremendous job in helping develop the dementia friendly community aspects, she's really excelled at developing partnerships and demonstrating how the AHP community can work.' [national strategic stakeholder]*

Specific examples of tailoring to meet the needs of people with dementia were highlighted such as: the fire service providing fire alarms and larger-than-normal ashtrays; staff at station facilities learning how to 'deal with' people who become disorientated; and faith group drop-ins for people from their religious background who have dementia.

> *'We've now got mental health nurses and others going into that to help support that. So it's beginning to build an infrastructure…to non-traditional groups and actually taking services to the group rather than patients having to come in and seek them.' [local strategic stakeholder]*

It was clear that the concept of dementia friendly communities had begun to spread throughout Scotland, and it was noted that Queen Margaret University had committed to becoming a 'dementia friendly educator'.

Dementia friendly communities were considered to provide an important mechanism for achieving high level population impact, in terms of quality of life and prolonging time living in the community. Furthermore, the dementia friendly communities were viewed as likely to be sustained in the long term.

An example: making dementia everyone's business

One of the Consultants had a particular focus on making dementia everyone's business. This involved raising awareness of ways a wide range of organisations could better tailor their services to improve quality of life and quality of care for people living with dementia.

The Consultant was pivotal in the development of two dementia friendly communities both within the host health board area [and the first of which attracted a COSLA award]. The Consultant, together with a manager from Alzheimer Scotland have presented on this work locally, nationally and internationally to share their experiences and insights.

Awareness sessions and training have been provided to an enormous number and range of organisations and individuals, including shops and superstores, Scotrail, Police Scotland, Fire and Rescue services [with every firefighter in the host health board trained], religious institutions, faith groups, health care facilities management staff, Royal National Institute for the Blind, and more.

In addition, by working in partnership with others, the Consultant has played a key role in establishing wider reminiscing opportunities. These have included engaging with/involving ex-players from the local football team, and people with links to the heavy industry plant that used to be a defining feature and source of employment in the area.

The Consultant, in partnership with others [including the Care Inspectorate] played a substantial role in developing *Making Every Moment Count* – a series of linked resources [leaflet, posters, DVD] primarily for care home services across Scotland, but also available to the NHS. This leaflet [for which the Care Inspectorate holds the copyright] has been distributed to every care service in Scotland – some 45,000 staff with the Consultant delivering sessions/training on this across Scotland. The resource is considered simple and effective. An independent evaluation of this resource concluded that the resource has been well received with some evidence of changed practices.

The Consultant was described as a 'dynamic driving force' in the local area with views that the changes that have come about in reaching so many diverse types of people in the area could be 'mapped back' to the Consultant and her work.

9.3 AHP views

There was also some evidence that the message about tailoring services to the needs of people with dementia was reaching AHPs beyond those who had had direct contact with the Consultants. For example, one physiotherapist spoke about a recent discussion she had with a dietician colleague who had trained as an AHP dementia champion. This physiotherapist reported that her colleague had explained how services could tailor what they do to make things easier for people living with dementia:

> *'…So I was asking her [colleague / AHP dementia champion] the other day, and I heard, you know, that… departments can make areas dementia friendly like, the sort of yellow clock, so that people with dementia can actually read the time easier.' [physiotherapist]*

9.4 Summary

This section has focused on the Consultants' role and impact in raising awareness among community organisations and services about the need to tailor approaches to better support people living with dementia. This aspect of the Consultants' work was about making dementia everyone's business, and there was praise among the national stakeholders for what this work had achieved across Scotland. There was also some modest evidence of this message being spread by AHP dementia champions in their local areas.

10. Improved information for people affected by dementia

The logic model included three short-term outcomes for people affected by dementia. These were: people affected by dementia have increased access to information on the AHP role; people affected by dementia become clearer about the AHP role and additionality; and AHP resources, services and partnerships are better informed by views of people affected by dementia.

While the success [or otherwise] of the Consultants in these respects was rarely mentioned in the interviews, one national strategic stakeholder expressed her belief that the first two of these outcomes were being achieved.

> *'I guess one of the main successes has been about promoting the role of the AHPs in treating people with dementia and their carers as well, and helping people to understand the benefits of that, for those with dementia and their carers, and helping them to understand how the AHPs can be seen as part of the bigger team. So raising that role with those with dementia, their carers, relatives, friends ….I think that's been a really big thing.'*

Importantly, this improved understanding was viewed as helping people affected by dementia access the services they need 'through *better understanding of what AHPs have to contribute to post-diagnostic support.'*

This view was endorsed by an interviewee affected by dementia who commented that previously *'I couldn't find leaflets and things like that to help me specifically with dementia with AHPs and when I was looking around there wasn't a lot'*, concluding that *'I think now there is more.'*

This individual went on to say that she sits on various committees with AHPs and that they have taken on board her comments when producing resources.

Importantly, the [newly produced] resources were considered to be positive and empowering:

> *'… I think now there is more, and it's written in a can-do attitude, …it's re-enabling them, it's lifting their spirits, it's a tool to give them something that "Here's something we can do."'*

The positive and empowering messages in these leaflets were described as sharply contrasting with other patients' leaflets, notably those that focus on impairments and [progressive] degeneration.

11. Views on maintenance and sustainability

National and local strategic interviewees were asked for their views regarding the future, in particular – whether they felt that the successes to date would be maintained, and whether/how the momentum attributed to the Consultants' activities would be sustained after the current funding for the posts comes to an end.

Confidence was expressed in relation to the sustainability of training for future and current AHPs. Interviewees pointed to changes that were likely to, or had, come about which they felt would help ensure the longevity of these two developments e.g. the likelihood of sustained government funding for training and education in dementia, a formalised partnership agreement between QMU and Alzheimer Scotland, confidence that QMU training modules will be retained, and, in one of the health boards – mandatory training for all AHPs who work within 'old age services'.

There was some confidence too that the dementia friendly communities would continue. Like the training, there was a view that there would be a national 'push' for continuation. Furthermore, the acknowledgement that dementia friendly cities created a supportive infrastructure - 'a driver for others to be involved' – was regarded as making their continuation likely.

However, national and local strategic stakeholders highlighted a number of issues regarding maintaining the momentum in other areas of the Consultant work over the longer term, and indeed producing the medium term outcomes as per the logic model.

> *'I think it depends on locally and nationally whether they are considered to be priorities, particularly locally. But I'm not sure that everything would continue…..There has to be some leadership around it and a continued drive, and see if you can keep that going.' [national strategic stakeholder]*

Outputs, such as leaflets, were considered to be at risk of being lost in the system, and indeed, going out of date very quickly.

Continuation of the work was seen to be dependent on having people to carry this forward, both locally and nationally.

> *'I think as long as key people who have worked with AHP Dementia Consultants within these organisations remain where they are, then the awareness of the contribution of allied health to the dementia agenda will remain, and hopefully some of those relationships will continue.' [national strategic stakeholder]*

At a national level, the Alzheimer Scotland AHP Expert Group was seen to be pivotal. Therefore, a need to maintain [and fund] this 'collective collaboration' was identified.

In one of the host health boards, succession planning was already in progress with champions in each of the AHP professions already being identified with a view to them picking up the baton.

However, interviewees also talked of the lack of certainty of allies, such as dementia champions, staying in their current roles. In fact, they highlighted that dementia champions are already leaving their posts and viewed this as a threat to ongoing progress and leadership at a grassroots level.

The value of maintaining the Consultant posts therefore emerged as a dominant theme with many interviewees expressing concerns about the momentum being sustained in the absence of dedicated Consultant posts.

> *'I think when you have people who are passionate about this agenda and making it their business to get in amongst it and to generate momentum and keep people engaged in this, then it's very difficult to say that would continue in the same way when they're not there.' [national stakeholder]*

> *'…without having my dementia consultant in post I would say at this moment in time, with knowing what's coming up over the next few years, I don't think we would maintain much of the momentum because there just wouldn't be the capacity. We could probably put some infrastructure in to keep it going, but I can think of other examples where when you lose your person who has got the dedicated leadership role, it becomes much more disparate, much more difficult to implement, and more importantly difficult to collate and recognise the difference.' [local strategic stakeholder]*

In two of the host health boards, conversations were already taking place locally to identify how the Consultant role could be retained or made substantive. In the third health board, this was not happening: there, it was felt that a business case for continuation could not be easily made because its Consultant role had involved a significant level of national work which, by definition, meant less time being invested in local activity.

> *'I think if we had the post full time, there would be a lot more opportunities, yes. So would I be supportive of the post continuing? Yes I would be. But in today's financial climate, that's just a non-starter…because she's half time in XXX and half time in a national role, there's a bit of sort of a divorce from the actual board itself, which has actually impacted negatively on the ability to continue with the post.' [local stakeholder]*

Therefore, it seemed that 'allowing' its Consultant to perform a national role had the unintended consequence of making it difficult to justify health board funding for the post.

12. Reflections and recommendations

This evaluation took a theory-driven approach. This involved: identifying what the Consultant programme evaluation has been trying to achieve and how; and collecting and considering evidence on the *plausibility* of outcomes being achieved as a consequence of the Consultants' activities. It should be acknowledged though that the Consultant work is taking place within a very favourable policy context, not just for dementia, but in other areas such as increased leadership for AHPs, the drive to keep the elderly living at home for longer, and the promotion of asset-based and person-centred care. The successes of the Consultants therefore cannot be divorced from the policy context in which they have been operating.

Feedback from the national and local strategic stakeholders in this evaluation has been overwhelmingly positive: they talked of Consultant successes in ways that were consistent with the outcomes defined in the logic model, and when they talked about what the Consultants actually did [their activities], they built a convincing case for these outcomes having been achieved [in full or in part] *because of* Consultant involvement.

It is, however, important to acknowledge that all stakeholder interviewees had a professional stake in aspects of the Consultant programme. While this, of course, meant that they commented from an *informed* position, the potential for some [positive] bias should be recognised. Notwithstanding the potential for bias, however, it is reassuring that there was significant agreement in the findings *across* the evaluation.

Despite some examples of evaluated activities, the absence of baseline data at the outset of the Consultant programme and a dearth of monitoring and evaluation information was identified as a weakness. Not only did this have implications for demonstrating and communicating the effectiveness of the Consultants in an ongoing manner, it meant that in this evaluation - participants were generally unable to point to tangible or objective indicators of success. As a consequence, the extent to which outcomes are being met through the efforts of the Consultants is not readily *quantifiable*. The take home lesson from this is that the Consultant programme would have benefited from more evaluative thinking at the outset i.e. clearer explication of intended outcomes, and an associated monitoring and evaluation plan.

Nevertheless, the Consultants were considered to have been highly effective as leaders within their own key result areas, not simply raising awareness but also increasing good dementia practices in targeted settings.

The findings suggest that the Consultants have indeed effected changes across a range of organisations: Alzheimer Scotland has become more attuned and committed to furthering AHP leadership and involvement in dementia care and support; AHPs' contribution to dementia care and support has achieved a higher prominence in host health boards, and these have also seen high numbers of AHPs trained and supported; in one health board area, progress has been made in improving in-patient discharge; care homes across Scotland have been targeted with a resource to improve the quality of interactions between workers and residents; community-based organisations have become 'dementia friendly'; and

Queen Margaret University is piloting new modules and is committed to a partnership with Alzheimer Scotland in order to strengthen AHPs' dementia capability.

The survey findings and AHP interviews suggest that the Consultants have been a valued resource, at least among those with whom the Consultants have had contact. Not only have the Consultants encouraged and energised them, there was evidence to indicate improved knowledge and practice, e.g. by using TAP, LACL, participating in dementia skills training, etc. On the basis of survey findings, however, it would seem that the impact on AHPs has not been consistent across Scotland. While the survey findings cannot be considered to be representative of all AHPs [and indeed survey response rates varied across health board areas], awareness of the Consultants and their work was higher in Lothian, Lanarkshire and Fife, although the findings in relation to Fife may relate to the relatively small number of respondents from that area. The low levels of awareness in Glasgow may reflect the Consultant focus there on one setting [acute hospital] and primarily within one locality [Glasgow North West]. In view of the aspiration to engender AHP leadership across Scotland, it would seem that the Consultants' reach and impact will not have been consistently felt.

It is perhaps too early to consider whether the Consultants' work has impacted positively on people affected by dementia in a significant way: their focus in the short-term has been primarily about building AHP capacity, capability and leadership. Nevertheless, the fact that Consultants' work was considered to be relevant and useful, and changed practices were reported, would suggest that it is highly plausible that improved experiences and outcomes for *some* people affected by dementia may have come about because of this work. Furthermore, one interviewee talked of her own experience of dementia and her belief that AHP practice has improved in recent years.

The approaches that the Consultants have been promoting and piloting are consistent with improved support and empowerment of people with dementia – a longer term outcome in the logic model. However, to aggregate improved outcomes and achieve high population level impact [and equity across Scotland], it will be important that AHP capability, capacity and leadership are strengthened across health and social care – statutory, third sector and private. The challenge for the future is how to achieve this consistently to ensure that people affected by dementia are not faced with a postcode lottery.

It was beyond the scope of this evaluation to drill down and establish what worked well and less well for the individual strands of each Consultants' work programme. Some of this might be 'in the heads' of the Consultants and so this tacit intelligence should be captured before the Consultants' contracts come to an end. This, together with insights from more formally evaluated activities and interventions [such as TAP, Making Every Moment Count, Dementia Friendly Communities, some of the training delivered to AHP students etc.] should be integrated, as appropriate, into the evidence base that is being developed/distilled by Alzheimer Scotland in fulfilment of Commitment 4.

While national and local stakeholders stressed that there will, of course, be limitations in how much can be achieved by just four Consultants since the establishment of this role, it was notable that a high percentage of survey respondents were unaware of the outputs produced by the Consultants and/or had had no contact with any of them. This is perhaps

unsurprising as the Consultants were often reliant on other conduits to reach AHPs across Scotland.

The Alzheimer Scotland AHP expert group was considered to be one such conduit, and distribution of the survey was carried out via the members of this group. While there are many possible reasons for the low response rate of this survey, candidate explanations might include members not having access to all AHPs in their local health board area and/or that they were *not* viewed as holding positions of influence.

The Alzheimer Scotland AHP expert group was considered to be pivotal in sustaining progress to date and for continuing to champion a stronger role, and changed practices, of AHPs in relation to dementia care and support. This raises questions as to whether its members are perceived as leaders and/or have the necessary influence to be effective in bringing about changed practices across the diverse AHP 'community', As many of those the AHPs who did complete the survey commented that they could not change their practice due to organisational/systemic pressures, it would be appear sensible to consider whether the current membership of the Alzheimer Scotland AHP expert group possess the requisite authority, connections and leadership to bring about the necessary service changes, and to ensure their sustainability. A similar consideration applies to the local AHP dementia champions as they are viewed as key players in carrying forward the agenda. As systemic change is more likely to be brought about by people with senior / management roles, it would seem that it would make sense that staff in positions of authority are targeted to become dementia champions.

The survey indicated that those who were familiar with the content of the three Consultant-produced publications considered them to be relevant. This is clearly good news. However, there was a sizeable proportion of AHP respondents who were unaware of these publications. As one of the intended audiences of these publications is AHPs, more consideration should be given to targeting the leaflets' distribution to ensure that their existence is widely known among the range of disciplines of this diverse professional group.

The critical issue is to be clear on what the various outputs [blogs, leaflets, community of practice] are expected to achieve, in whom, and how. If, for example, the leaflets are intended for non-AHP professions [too], then it will be important to be clear on [precisely] what types of roles should be targeted. It would seem likely that these should include managers and decision-makers who influence things like staffing ratios, the nature of their roles and responsibilities and who can mandate for associated skills-development, referral pathways, and monitoring processes.

The survey findings indicated low awareness of the blog and the vast majority of respondents who were aware of it, seldom or never looked at / read it. If the blog is indeed considered to be a mechanism for increasing AHP knowledge and enthusiasm for new / best practices, there would be obvious advantages in finding out why these are so infrequently read. In turn, informed decisions should be taken on whether they should be continued, and if so, what changes should be made to them.

Some interviewees pointed to developments that they felt would ensure that the improved outcomes brought about by the Consultants would endure irrespective of any continuation

of the role. Others were of the view that there was a need for continued leadership and two of the host health boards are looking at ways to make the post substantive in order to consolidate and build on gains to date. Not only does this testify to the value that they place on their respective Consultants [as was the case with all three health boards], it suggests local ownership and commitment to the agenda of enhanced AHP involvement in dementia care and support. This is what the programme aimed to achieve when NHS boards were invited to submit a bid in the first place. In the case of the third host health board, there was a view that it would be difficult to create a viable business case for continuation of the role due to its Consultant's high level of activity outwith the host health board area. In hindsight, it might have been useful if: the memorandum of agreement between the Scottish Government and the host health boards had more tightly specified and formalised the division of time between national and local activity; and if there had been formalised reporting arrangements on this issue both within the boards, and between each board and the Scottish Government.

The logic model indicates that the vision is for a visible, empowered and skilled AHP workforce providing timely, high quality care and support; and integration of AHPs in systemic and sustained commitments to dementia care and support. Together, these are expected to contribute to people with dementia flourishing for longer. There may therefore be considerable value in Alzheimer Scotland refining this logic model through consultation with others, encouraging buy-in to agreed medium term outcomes, and together with the Scottish Government – using this to communicate and maintain strategic direction. Finally, as indicated in this evaluation, future strategic planning should be partnered with sound, proportionate and ongoing monitoring and evaluation. Doing so will not only enable assessments of where changes are being made and to what level, but also will provide a stronger basis for making decisions on whether and how activities should be refined.

Appendix 1: Participants in logic modelling sessions

- Jan Beatie, AHP officer primary care, Scottish Government
- Kate Fearney, Deputy CEO, Alzheimer Scotland
- Elaine Hunter, AHP Dementia Consultant, Alzheimer Scotland
- Alison Meiklejohn, AHP Mental Health lead representing the AHP Director for NHS Lothian
- Peter McCrossan, AHP Director, NHS Lanarkshire
- Julie McKelvie, AHP Mental Health lead representing the AHP Director for NHS Greater Glasgow and Clyde
- Jenny Reid, AHP Dementia Consultant, NHS Lothian
- Sandra Shafii, AHP Dementia Consultant, NHS Lanarkshire
- Christine Steel, AHP Dementia Consultant, NHS Greater Glasgow and Clyde

Appendix 2: Survey findings

A2.1. General information about respondents

Respondents, by job role

Which of the following best describes your role?	n	%
Occupational therapist	168	44%
Physiotherapist	77	20%
Dietician	48	13%
Speech and language therapist	41	11%
Podiatrist or Chiropodist	25	7%
Arts therapist [Art, Music or Drama]	6	2%
Radiographer	4	1%
Prosthetist or Orthotist	3	1%
Orthoptist	3	1%
Other health professional [doctor or nurse]	8	2%
Total	383	100%

Respondents, by employing organisation

Are you employed by:	n	%
NHS	344	92%
A local authority	25	7%
Other*	5	1%
Total	374	100%

* Other: Third sector, Higher education, Private practice.

Respondents, by location of work

Work predominantly with people in:	n	%
Community	185	50%
Hospitals	144	39%
Hospitals, community & care homes	18	5%
Hospitals & community	10	3%
Community & care homes	7	2%
Care homes	5	1%
Hospitals & care homes	1	0%
Total	370	100%

Respondents, by NHS Board

NHS Board Area	n	%
Greater Glasgow & Clyde	69	19%
Lothian	60	16%
Grampian	50	13%
Tayside	41	11%
Lanarkshire	35	9%
South Scotland Boards*	34	9%
Island Boards**	31	8%
Highland	20	5%
Fife	17	5%
Forth Valley	14	4%
Total	371	100%

* South Scotland Boards: Ayrshire & Arran, Dumfries & Galloway, Borders
** Island Boards: Orkney, Shetland, Western Isles

Are you [officially] a ‘dementia champion’ in your area?

	n	%
Yes	25	7%
No	343	93%
Not sure	2	1%
Total	370	100%

A2.2. Awareness of publications / resources produced by AHP Dementia Consultants

Awareness of the National AHPs Best Practice in Dementia Network website [i.e. the AHP Dementia Community of Practice], by NHS Board [n]

NHS Board Area	I have not seen this website	I have seen this website, but have not used it	I have used this website occasionally	I have used this website frequently	Total
Fife	4	6	7	--	17
Forth Valley	4	7	2	1	14
Grampian	25	13	9	1	48
Greater Glasgow & Clyde	29	25	9	3	66
Highland	4	6	10	--	20
Island Boards	17	7	5	2	31
Lanarkshire	9	8	15	3	35
Lothian	15	18	21	6	60
South Scotland Boards	12	6	11	5	34
Tayside	15	18	8	--	41
Total	134	114	97	21	366

* South Scotland Boards: Ayrshire & Arran, Dumfries & Galloway, Borders
** Island Boards: Orkney, Shetland, Western Isles

Awareness of the National AHPs Best Practice in Dementia Network website [i.e. the AHP Dementia Community of Practice], by NHS Board [%]

NHS Board Area	I have not seen this website	I have seen this website, but have not used it	I have used this website occasionally	I have used this website frequently	Total
Fife	24%	35%	41%	0%	100%
Forth Valley	29%	50%	14%	7%	100%
Grampian	52%	27%	19%	2%	100%
Greater Glasgow & Clyde	44%	38%	14%	5%	100%
Highland	20%	30%	50%	0%	100%
Island Boards	55%	23%	16%	6%	100%
Lanarkshire	26%	23%	43%	9%	100%
Lothian	25%	30%	35%	10%	100%
South Scotland Boards	35%	18%	32%	15%	100%
Tayside	37%	44%	20%	0%	100%
Total	37%	31%	27%	6%	100%

* South Scotland Boards: Ayrshire & Arran, Dumfries & Galloway, Borders
** Island Boards: Orkney, Shetland, Western Isles

Awareness of the National AHPs Best Practice in Dementia Network website [i.e. the AHP Dementia Community of Practice], by role [n]

Role	I have not seen this website	I have seen this website, but have not used it	I have used this website occasionally	I have used this website frequently	Total
Occupational therapist	53	49	47	16	165
Physiotherapist	29	26	17	2	74
Dietician	25	11	11	1	48
Speech and language therapist	10	14	16	1	41
Other AHP	17	14	6	1	38
Total	134	114	97	21	366

Awareness of the National AHPs Best Practice in Dementia Network website [i.e. the AHP Dementia Community of Practice], by role [%]

Role	I have not seen this website	I have seen this website, but have not used it	I have used this website occasionally	I have used this website frequently	Total
Occupational therapist	32%	30%	28%	10%	100%
Physiotherapist	39%	35%	23%	3%	100%
Dietician	52%	23%	23%	2%	100%
Speech and language therapist	24%	34%	39%	2%	100%
Other AHP	45%	37%	16%	3%	100%
Total	37%	31%	27%	6%	100%

Awareness of the publication: "Allied Health Professionals Dementia Champions: Agents of Change", by NHS Board [n]

NHS Board Area	I have not previously seen this publication	I have seen this publication, but have not read it	I have read some, but not much of the publication	I have read most / all of this publication	Total
Fife	2	4	7	4	17
Forth Valley	6	3	4	1	14
Grampian	24	14	6	5	49
Greater Glasgow & Clyde	34	16	8	8	66
Highland	8	--	7	5	20
Island Boards	17	6	3	4	30
Lanarkshire	11	4	7	12	34
Lothian	14	11	19	16	60
South Scotland Boards	7	5	5	17	34
Tayside	18	6	10	6	40
Total	141	69	76	78	364

* South Scotland Boards: Ayrshire & Arran, Dumfries & Galloway, Borders

** Island Boards: Orkney, Shetland, Western Isles

Awareness of the publication: "Allied Health Professionals Dementia Champions: Agents of Change", by NHS Board [%]

NHS Board Area	I have not previously seen this publication	I have seen this publication, but have not read it	I have read some, but not much of the publication	I have read most / all of this publication	Total
Fife	12%	24%	41%	24%	100%
Forth Valley	43%	21%	29%	7%	100%
Grampian	49%	29%	12%	10%	100%
Greater Glasgow & Clyde	52%	24%	12%	12%	100%
Highland	40%	0%	35%	25%	100%
Island Boards	57%	20%	10%	13%	100%
Lanarkshire	32%	12%	21%	35%	100%
Lothian	23%	18%	32%	27%	100%
South Scotland Boards	21%	15%	15%	50%	100%
Tayside	45%	15%	25%	15%	100%
Total	39%	19%	21%	21%	100%

* South Scotland Boards: Ayrshire & Arran, Dumfries & Galloway, Borders

** Island Boards: Orkney, Shetland, Western Isles

Awareness of publication: "Allied Health Professionals Dementia Champions: Agents of Change", by role [n]

Role	I have not previously seen this publication	I have seen this publication, but have not read it	I have read some, but not much of the publication	I have read most / all of this publication	Total
Dietician	27	9	4	7	47
Occupational therapist	50	29	42	43	164
Physiotherapist	37	15	11	10	73
Speech and language therapist	9	7	13	12	41
Other AHP	18	10	6	5	39
Total	141	70	76	77	364

Awareness of publication: "Allied Health Professionals Dementia Champions: Agents of Change", by role [%]

Role	I have not previously seen this publication	I have seen this publication, but have not read it	I have read some, but not much of the publication	I have read most / all of this publication	Total
Dietician	57%	19%	9%	15%	100%
Occupational therapist	30%	18%	26%	26%	100%
Physiotherapist	51%	21%	15%	14%	100%
Speech and language therapist	22%	17%	32%	29%	100%
Other AHP	46%	26%	15%	13%	100%
Total	39%	19%	21%	21%	100%

Awareness of the publication: "Allied Health Professionals Delivering Post-Diagnostic Support: Living Well with Dementia", by NHS Board [n]

NHS Board Area	I have not previously seen this publication	I have seen this publication, but have not read it	I have read some, but not much of the publication	I have read most / all of this publication	Total
Fife	1	4	4	7	16
Forth Valley	5	4	2	3	14
Grampian	31	11	2	4	48
Greater Glasgow & Clyde	43	11	7	6	67
Highland	6	4	5	5	20
Island Boards	21	6	2	1	30
Lanarkshire	11	4	5	14	34
Lothian	19	12	16	12	59
South Scotland Boards	8	8	2	16	34
Tayside	19	9	8	4	40
Total	164	73	53	72	362

* South Scotland Boards: Ayrshire & Arran, Dumfries & Galloway, Borders

** Island Boards: Orkney, Shetland, Western Isles

Awareness of the publication: "Allied Health Professionals Delivering Post-Diagnostic Support: Living Well with Dementia", by NHS Board [%]

NHS Board Area	I have not previously seen this publication	I have seen this publication, but have not read it	I have read some, but not much of the publication	I have read most / all of this publication	Total
Fife	6%	25%	25%	44%	100%
Forth Valley	36%	29%	14%	21%	100%
Grampian	65%	23%	4%	8%	100%
Greater Glasgow & Clyde	64%	16%	10%	9%	100%
Highland	30%	20%	25%	25%	100%
Island Boards	70%	20%	7%	3%	100%
Lanarkshire	32%	12%	15%	41%	100%
Lothian	32%	20%	27%	20%	100%
South Scotland Boards	24%	24%	6%	47%	100%
Tayside	48%	23%	20%	10%	100%
Total	45%	20%	15%	20%	100%

* South Scotland Boards: Ayrshire & Arran, Dumfries & Galloway, Borders

** Island Boards: Orkney, Shetland, Western Isles

Awareness of the publication: "Allied Health Professionals Delivering Post-Diagnostic Support: Living Well with Dementia", by role [n]

Role	I have not previously seen this publication	I have seen this publication, but have not read it	I have read some, but not much of the publication	I have read most / all of this publication	Total
Dietician	31	7	3	6	47
Occupational therapist	56	35	25	46	162
Other AHP	24	6	5	4	39
Physiotherapist	42	11	13	7	73
Speech and language therapist	11	14	8	8	41
Total	164	73	54	71	362

Awareness of the publication: "Allied Health Professionals Delivering Post-Diagnostic Support: Living Well with Dementia", by role [%]

Role	I have not previously seen this publication	I have seen this publication, but have not read it	I have read some, but not much of the publication	I have read most / all of this publication	Total
Dietician	66%	15%	6%	13%	100%
Occupational therapist	35%	22%	15%	28%	100%
Other AHP	62%	15%	13%	10%	100%
Physiotherapist	58%	15%	18%	10%	100%
Speech and language therapist	27%	34%	20%	20%	100%
Total	45%	20%	15%	20%	100%

Awareness of the publication: "Allied Health Professionals Delivering Integrated Dementia Care: Living Well with Community Support", by NHS Board [n]

NHS Board Area	I have not previously seen this publication	I have seen this publication, but have not read it	I have read some, but not much of the publication	I have read most / all of this publication	Total
Fife	7	2	4	4	17
Forth Valley	6	4	2	2	14
Grampian	36	6	3	3	48
Greater Glasgow & Clyde	48	4	8	5	65
Highland	8	4	4	4	20
Island Boards	23	5	1	0	29
Lanarkshire	11	8	4	10	33
Lothian	32	12	8	8	60
South Scotland Boards	15	7	2	10	34
Tayside	23	7	7	2	39
Total	209	59	43	48	359

* South Scotland Boards: Ayrshire & Arran, Dumfries & Galloway, Borders

** Island Boards: Orkney, Shetland, Western Isles

Awareness of the publication: "Allied Health Professionals Delivering Integrated Dementia Care: Living Well with Community Support", by NHS Board [%]

NHS Board Area	I have not previously seen this publication	I have seen this publication, but have not read it	I have read some, but not much of the publication	I have read most / all of this publication	Total
Fife	41%	12%	24%	24%	100%
Forth Valley	43%	29%	14%	14%	100%
Grampian	75%	13%	6%	6%	100%
Greater Glasgow & Clyde	74%	6%	12%	8%	100%
Highland	40%	20%	20%	20%	100%
Island Boads	79%	17%	3%	0%	100%
Lanarkshire	33%	24%	12%	30%	100%
Lothian	53%	20%	13%	13%	100%
South Scotland Boads	44%	21%	6%	29%	100%
Tayside	59%	18%	18%	5%	100%
Total	58%	16%	12%	13%	100%

* South Scotland Boards: Ayrshire & Arran, Dumfries & Galloway, Borders

** Island Boards: Orkney, Shetland, Western Isles

Awareness of the publication: "Allied Health Professionals Delivering Integrated Dementia Care: Living Well with Community Support", by role [n]

Role	I have not previously seen this publication	I have seen this publication, but have not read it	I have read some, but not much of the publication	I have read most / all of this publication	Total
Dietician	31	5	6	4	46
Occupational therapist	78	29	23	31	161
Physiotherapist	54	9	5	5	73
Speech and language therapist	17	12	7	4	40
Other AHP	28	4	3	4	39
Total	208	59	44	48	359

Awareness of the publication: "Allied Health Professionals Delivering Integrated Dementia Care: Living Well with Community Support", by role [%]

Role	I have not previously seen this publication	I have seen this publication, but have not read it	I have read some, but not much of the publication	I have read most / all of this publication	Total
Dietician	67%	11%	13%	9%	100%
Occupational therapist	48%	18%	14%	19%	100%
Physiotherapist	74%	12%	7%	7%	100%
Speech and language therapist	43%	30%	18%	10%	100%
Other AHP	72%	10%	8%	10%	100%
Total	58%	16%	12%	13%	100%

Awareness of the leaflet: "Make Every Moment Count", by NHS Board [n]

NHS Board Area	I have not previously seen this leaflet	I have seen this leaflet, but have not read it	I have read some of this leaflet	I have read most / all of this leaflet	Total
Fife	3	--	--	7	10
Forth Valley	3	1	--	1	5
Grampian	4	2	--	8	14
Greater Glasgow & Clyde	9	4	4	3	20
Highland	5	1	2	3	11
Island Boards	3	1	2	3	9
Lanarkshire	8	--	5	7	20
Lothian	11	7	5	12	35
South Scotland Boards	5	2	4	6	17
Tayside	7	2	2	6	17
Total	58	20	24	56	158

* South Scotland Boards: Ayrshire & Arran, Dumfries & Galloway, Borders
** Island Boards: Orkney, Shetland, Western Isles

Awareness of the leaflet: "Make Every Moment Count", by NHS Board [%]

NHS Board Area	I have not previously seen this leaflet	I have seen this leaflet, but have not read it	I have read some of this leaflet	I have read most / all of this leaflet	Total
Fife	30%	0%	0%	70%	100%
Forth Valley	60%	20%	0%	20%	100%
Grampian	29%	14%	0%	57%	100%
Greater Glasgow & Clyde	45%	20%	20%	15%	100%
Highland	45%	9%	18%	27%	100%
Island Boards	33%	11%	22%	33%	100%
Lanarkshire	40%	0%	25%	35%	100%
Lothian	31%	20%	14%	34%	100%
South Scotland Boards	29%	12%	24%	35%	100%
Tayside	41%	12%	12%	35%	100%
Total	37%	13%	15%	35%	100%

* South Scotland Boards: Ayrshire & Arran, Dumfries & Galloway, Borders
** Island Boards: Orkney, Shetland, Western Isles

Awareness of the leaflet: "Make Every Moment Count", by role [n]

Role	I have not previously seen this leaflet	I have seen this leaflet, but have not read it	I have read some of this leaflet	I have read most / all of this leaflet	Total
Dietician	7	--	4	8	19
Occupational therapist	28	8	13	35	84
Physiotherapist	12	5	5	7	29
Speech and language therapist	7	3	2	5	17
Other AHP	5	4	--	1	10
Total	59	20	24	56	159

Awareness of the leaflet: "Make Every Moment Count", by role [%]

Role	I have not previously seen this leaflet	I have seen this leaflet, but have not read it	I have read some of this leaflet	I have read most / all of this leaflet	Total
Dietician	37%	0%	21%	42%	100%
Occupational therapist	33%	10%	15%	42%	100%
Physiotherapist	41%	17%	17%	24%	100%
Speech and language therapist	41%	18%	12%	29%	100%
Other AHP	50%	40%	0%	10%	100%
Total	37%	13%	15%	35%	100%

Awareness of the on-line blog: "Let's Talk about Dementia", by NHS Board [n]

NHS Board Area	I have not previously seen this	I have seen this, but have not read it	I seldom read this	I sometimes read this	I read this regularly	Total
Fife	10	3	--	3	1	17
Forth Valley	10	1	--	2	1	14
Grampian	34	10	1	3	--	48
Greater Glasgow & Clyde	45	14	2	1	4	66
Highland	6	5	2	5	2	20
Island Boards	26	3	--	--	--	29
Lanarkshire	13	4	4	9	3	33
Lothian	27	9	4	15	5	60
South Scotland Boards	12	3	2	11	6	34
Tayside	24	4	4	5	2	39
Total	207	56	19	54	24	360

* South Scotland Boards: Ayrshire & Arran, Dumfries & Galloway, Borders

** Island Boards: Orkney, Shetland, Western Isles

Awareness of the on-line blog: "Let's Talk about Dementia", by NHS Board [%]

NHS Board Area	I have not previously seen this	I have seen this, but have not read it	I seldom read this	I sometimes read this	I read this regularly	Total
Fife	59%	18%	0%	18%	6%	100%
Forth Valley	71%	7%	0%	14%	7%	100%
Grampian	71%	21%	2%	6%	0%	100%
Greater Glasgow & Clyde	68%	21%	3%	2%	6%	100%
Highland	30%	25%	10%	25%	10%	100%
Island Boards	90%	10%	0%	0%	0%	100%
Lanarkshire	39%	12%	12%	27%	9%	100%
Lothian	45%	15%	7%	25%	8%	100%
South Scotland Boards	35%	9%	6%	32%	18%	100%
Tayside	62%	10%	10%	13%	5%	100%
Total	58%	16%	5%	15%	7%	100%

* South Scotland Boards: Ayrshire & Arran, Dumfries & Galloway, Borders

** Island Boards: Orkney, Shetland, Western Isles

Awareness of the on-line blog: "Let's Talk about Dementia", by role [n]

Role	I have not previously seen this	I have seen this, but have not read it	I seldom read this	I sometimes read this	I read this regularly	Total
Dietician	31	6	--	9	1	47
Occupational therapist	82	27	10	31	11	161
Physiotherapist	51	13	3	2	4	73
Speech and language therapist	20	4	6	6	4	40
Other AHP	24	6	--	6	3	39
Total	208	56	19	54	23	360

Awareness of the on-line blog: "Let's Talk about Dementia", by role [%]

Role	I have not previously seen this	I have seen this, but have not read it	I seldom read this	I sometimes read this	I read this regularly	Total
Dietician	66%	13%	0%	19%	2%	100%
Occupational therapist	51%	17%	6%	19%	7%	100%
Other AHP	62%	15%	0%	15%	8%	100%
Physiotherapist	70%	18%	4%	3%	5%	100%
Speech and language therapist	50%	10%	15%	15%	10%	100%
Total	58%	16%	5%	15%	6%	100%

Awareness of the quarterly electronic newsletter: "Dementia AHPproaches", by NHS Board [n]

NHS Board	I have not previously seen this	I have seen this, but have not read it	I seldom read this	I sometimes read this	I read this regularly	Total
Fife	7	--	1	2	7	17
Forth Valley	9	--	--	3	2	14
Grampian	29	5	2	5	7	48
Greater Glasgow & Clyde	44	1	3	9	8	65
Highland	8	1	1	8	2	20
Island Boards	19	1	--	5	4	29
Lanarkshire	11	2	--	6	14	33
Lothian	17	8	5	12	18	60
South Scotland Boards	15	2	4	4	9	34
Tayside	17	5	2	8	7	39
Total	176	25	18	62	78	359

* South Scotland Boards: Ayrshire & Arran, Dumfries & Galloway, Borders

** Island Boards: Orkney, Shetland, Western Isles

Awareness of the quarterly electronic newsletter: "Dementia AHPproaches", by NHS Board [%]

NHS Board	I have not previously seen this	I have seen this, but have not read it	I seldom read this	I sometimes read this	I read this regularly	Total
Fife	41%	0%	6%	12%	41%	100%
Forth Valley	64%	0%	0%	21%	14%	100%
Grampian	60%	10%	4%	10%	15%	100%
Greater Glasgow & Clyde	68%	2%	5%	14%	12%	100%
Highland	40%	5%	5%	40%	10%	100%
Island Boards	66%	3%	0%	17%	14%	100%
Lanarkshire	33%	6%	0%	18%	42%	100%
Lothian	28%	13%	8%	20%	30%	100%
South Scotland Boards	44%	6%	12%	12%	26%	100%
Tayside	44%	13%	5%	21%	18%	100%
Total	49%	7%	5%	17%	22%	100%

* South Scotland Boards: Ayrshire & Arran, Dumfries & Galloway, Borders
** Island Boards: Orkney, Shetland, Western Isles

Awareness of the quarterly electronic newsletter: "Dementia AHPproaches", by role [n]

Role	I have not previously seen this	I have seen this, but have not read it	I seldom read this	I sometimes read this	I read this regularly	Total
Dietician	23	5		9	10	47
Occupational therapist	67	10	7	28	49	161
Physiotherapist	40	3	7	11	11	72
Speech and language therapist	21	2	3	7	7	40
Other AHP	24	5	1	8	1	39
Total	175	25	18	63	78	359

Awareness of the quarterly electronic newsletter: "Dementia AHPproaches", by role [%]

Role	I have not previously seen this	I have seen this, but have not read it	I seldom read this	I sometimes read this	I read this regularly	Total
Dietician	49%	11%	0%	19%	21%	100%
Occupational therapist	42%	6%	4%	17%	30%	100%
Other AHP	62%	13%	3%	21%	3%	100%
Physiotherapist	56%	4%	10%	15%	15%	100%
Speech and language therapist	53%	5%	8%	18%	18%	100%
Total	49%	7%	5%	18%	22%	100%

A2.3. Respondents' views about the relevance of publications and resources produced by the AHP Dementia Consultants

Thinking about the publication, "Allied Health Professionals Dementia Champions: Agents of Change", how useful / relevant did you find this publication?

	n	%
Not useful / relevant	5	3%
Somewhat useful / relevant	75	48%
Very useful / relevant	76	49%
Total	156	100%

Thinking about the publication, "Allied Health Professionals Delivering Post-Diagnostic Support: Living Well with Dementia", how useful / relevant did you find this publication?

	n	%
Not useful / relevant	3	2%
Somewhat useful / relevant	50	39%
Very useful / relevant	74	58%
Total	127	100%

Thinking about the publication, "Allied Health Professionals Delivering Post-Diagnostic Support: Living Well with Dementia", how useful / relevant did you find this publication?

	n	%
Not useful / relevant	2	2%
Somewhat useful / relevant	41	45%
Very useful / relevant	49	53%
Total	92	100%

Thinking about the on-line blog "Let's Talk about Dementia", how useful / relevant do you find this publication?

	n	%
Not useful / relevant	6	6%
Somewhat useful / relevant	45	48%
Very useful / relevant	43	46%
Total	94	100%

Thinking about the quarterly electronic newsletter, "Dementia AHPproaches", how useful / relevant do you find this publication?

	n	%
Not useful / relevant	3	2%
Somewhat useful / relevant	75	47%
Very useful / relevant	80	51%
Total	158	100%

Thinking about the leaflet, "Make Every Moment Count", how useful / relevant did you find it?

	n	%
Not useful / relevant	2	3%
Somewhat useful / relevant	27	34%
Very useful / relevant	51	64%
Total	80	100%