

Dementia Adventure in a Box

Final Evaluation Report

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1. Executive Summary

Over 30 years ago, the biologist Edward Osborne Wilson proposed the Biophilia Hypothesis, asserting that human beings have an evolutionary drive to interact with

nature that makes it essential to our psychological health. Since then a growing body of evidence has highlighted the potential for connecting with nature to improve quality of life and wellbeing for everyone.



Dementia Adventure is a social enterprise with an overarching aim to build long term innovative and mutually beneficial partnerships which directly increase the choices on offer for people living with dementia – specifically connecting them to outdoor nature-based adventures through the support of confident, trained

Dementia Adventure leaders. Dementia Adventure received funding from the Big Lottery to pilot a social franchise, named Dementia Adventure in A Box (DAiAB), across five licensee organisations over the period 2017-2020.

One of the five license partners that signed up to the project left within the first few months due to different perspectives and priorities. Therefore, this report is based on data that was collected from four organisations. Each delivery partner committed to identifying a minimum of eight delegates across their organisation, enabling the work to be piloted in over 40 localities. Training was to be cascaded to a maximum of 50 further staff and volunteers through a mixture of blended on and offline method of delivery and via the licenced delegates. Each organisation aimed to implement and establish a programme of regular outdoor activities that would leave a legacy of support for people living with dementia. They also agreed to provide sufficient evaluation data sets in order to learn, adapt, and collate evidence to support a sustainable licence model.

Evaluation of this pilot project was led by The Association for Dementia Studies and carried out in collaboration with the Green Exercise Research Team at the University of Essex. A mixed methods approach was used to obtain both quantitative and qualitative insight.

Delegates

A total of 64 delegates were involved in activities across 44 locations. 25 delegates left during the project. Of these, five left their organisation and were replaced (this includes two who went on maternity leave), five left and were not replaced, and 15 left the project for unspecified reasons.

Training

29 'core' training days (a set of five individual days, each with a different focus) were completed and evaluated by 68 delegates, as were 64 additional stand-alone training days. The training days were positively received and highly rated. All delegates who completed the evaluation forms said that they would recommend each of the days they attended, that each day had met its objectives and that the content was relevant. Pre- and post-training measures indicated that the training was associated with increased delegate understanding of dementia and confidence about working with people living with dementia.

Training took place over a long period of time, with significant time elapsing between sessions. This approach aimed to meet the needs of organisations who might struggle to release staff for training on a more frequent basis. However, it did mean that delegates were required to organise, deliver and evaluate activity sessions before they had completed the full 5-day training programme. Many delegates appeared reluctant to start delivering sessions until they had been on at least a few of the training days. Only 11 delegates completed all five days of training; this may be related to a relatively high level of staff turnover.

Activity Sessions

913 activity sessions were held as part of this project (164 one-off sessions and 779 sessions as part of 33 different activity series). 636 of these were nature-based, and 581 took place outdoors. 2490 activity attendances were recorded by people living with dementia and 582 by carers.

Participants

From information provided by delegates through formal reporting it was possible to identify 35 people with dementia and 15 carers who attended activities and were part of the evaluation. 126 other people attended activities but did not engage with the evaluation. On average, the people with dementia were aged approximately 80 years and 8 months, 64% were female, and, where information was provided, everyone was White British. The average age of the carers was 60 years and 2 months, 83% were female and, where given, everyone was White British.

Quantitative Findings for Participants

The data collected indicated that DAiAB sessions improved the self-reported wellbeing of people living with dementia and family carers, by 16 – 18%; and for participants with dementia, most of the benefit appeared to occur during individual sessions rather than being maintained over time. Sessions also increased participants' self-reported weekly activity levels by 0.5 days, to just over 2 days. This indicates that the DAiAB sessions formed an important proportion of weekly physical activity for people with dementia.

Qualitative Findings for Participants

The case study findings clearly demonstrated a range of benefits associated with taking part in the project. For participants with dementia, these included improved wellbeing and mood, as well as valuable opportunities for social interaction. There was a strong feeling that participants enjoyed the activities provided for a number of reasons, particularly the fact that they took place outdoors and were relaxed and informal. The personalised nature of the activities was also valued, which meant that they were meaningful and helped maintain a sense of identity. It was felt that undertaking 'real' tasks was fulfilling for participants, although the importance of not asking too much of those living with dementia, particularly in terms of time, was also stressed.

Project learning for delegates and organisations

For the organisations involved, the benefits included access to specialist training, which led to increased confidence, satisfaction and motivation among delegates. For those organisations that didn't previously work with people affected by dementia, the project enabled them to access a whole new client group. For those organisations who did, it allowed them to expand and improve their provision, while also offering new types of activities.

Challenges to successful implementation of the project included recruiting people to take part in activities (particularly for organisations who had not previously been supporting people living with dementia), transport, funding, and perceptions about dementia-related stigma, which influenced how the activities were publicised and branded in some situations. However, the creative ways in which many of these challenges were addressed highlights the substantial amount of learning and innovation that occurred.

The case study findings also suggest that the structure and culture of provider organisations can be a significant factor in the success of the project. For example, those that provide arms-length services/support to diverse locations faced different challenges to those that operate within a more corporate or standardised model. Similarly, some providers made the coordinator role the sole focus of a post, while

others added it to an existing role. There are likely to be benefits and drawbacks to both approaches, and the personalities and skills of individuals may be equally important, but our findings suggest that the coordinator role has operated more successfully in some organisations than in others.

The data captured indicate that there is no appropriate ‘one size fits all’ approach to implementing DAiAB; individual and organisational circumstances need to be considered.

Physical activity monitor data

A small amount of physical activity data were recorded from DAiAB participants living with dementia using wearable technology. The findings indicated that people living with dementia recorded higher physical activity levels on days when they attended project activities. The collection of this data is in itself important as a proof of concept. Research has rarely attempted or been successful with such approaches involving individuals living with dementia.

Challenges for the evaluation

Several challenges to taking part in the evaluation became apparent as the project progressed. These focused on differing perceptions of the value of quantitative and qualitative evidence, concerns about recruiting participants to take part in the evaluation, and a feeling among some delegates that they didn’t have enough support in using the evaluation tools. Although some aspects of the evaluation were altered to address concerns as the project progressed, this insight suggests a need to engage with delegates far earlier in project development, and to be realistic about the resources that are required to provide adequate support with evaluation activities within such a large and complex initiative.

The learning evidenced in the case studies helped to shape and improve the project as it progressed and also provides crucial evidence to inform develop of the DAiAB model going forwards.

Conclusions and Recommendations

The broad picture presented in this report confirms the importance of connecting with nature for people living with dementia and highlights a successful project that met the majority of its targets. For example, 3072 people attended activities against a target of 2034, a diverse range of activities were held and there was a significant increase in wellbeing scores for people living with dementia and carers who took part. For some other indicators the project came close to meeting its targets. For example, 913 activities were held as part of the project against a target of 1152. Delegate Job Satisfaction was the one indicator that saw a noticeable decrease, a

finding that merits further exploration. Overall, the evaluation certainly suggests that the project achieved the overarching project outcome of ‘People living with dementia are given opportunities and support to access the natural environment, leading to improved health and wellbeing’.

This report provides strong evidence of positive impacts for people living with dementia and carers who took part in the project. In addition to identifying a range of impacts associated with the delivery of nature-based activities for people living with dementia and their carers, the findings presented in this report provide substantial learning that can be used to inform any further development and delivery of the ‘Dementia Adventure in a Box’ initiative.

The following key recommendations have been developed based on our evaluation findings :

- Adaptations to the training model should be considered.
- If evaluation is to be an element of the DAiAB offer going forwards, it should have a higher profile within the ongoing training programme.
- Careful consideration is required when deciding which provider organisations are best suited to the DAiAB model.
- Providers might benefit from more structured support in getting the project started. This could include role descriptors for co-ordinators and delegates, templates for delegates to use when approaching potential partnership organisations.
- Greater clarity is required concerning the resources, including funding, that are required to successfully deliver the project and where these resources might come from.
- Dementia Adventure branding is a valuable resource that has been used to varying degrees in the pilot. We suggest that it should be adopted more widely.

The full set of recommendations can be found on page 85.

2. The ‘Dementia Adventure in a Box’ project

‘Dementia Adventure’ is a social enterprise with an overall objective to build long term innovative and mutually beneficial partnerships which directly increase the choices on offer for people living with dementia – specifically connecting them to outdoor nature-based adventures through the support of confident, trained Dementia Adventure leaders.

Recognising that the core Dementia Adventure team can only reach a relatively small number of people, Dementia Adventure was keen to explore the concept of ‘social licencing’. Social licencing is a form of replication and scaling that lies in the middle ground between the simple dissemination of an idea and formal wholly owned local or regional branches. Dementia Adventure wants to remain a relatively small organisation that makes a big impact. It is hoped that by working with licenced organisations who are socially driven they can deliver more locally needed services by using their expertise and achieving a healthy balance between the freedom to initiate a range of local activities that adds value to the local organisations and ensuring these activities are implemented well. Through operational activity delivered locally, jointly branded and delivered with skilled, experienced and confident staff in partner organisations, the aim is to share innovation, share financial modelling and harness local resources for the benefit of more people with dementia.



Under the social licence scheme, an entry level licence runs for 12 months and provides a range of benefits including course materials, face-to-face staff and volunteer training days, specialist online resources, branded materials and regular reviews. Further to the success of the scheme with one local authority in Scotland, Dementia Adventure received funding from the Big Lottery for to extend the pilot to 5 more licences over the period 2017-2020. This included funding for an evaluation

of the pilot, which was led by The Association for Dementia Studies and carried out in collaboration with the Green Exercise Research Team at the University of Essex.

Five organisations with diverse structures and operating practices were recruited by Dementia Adventure to be delivery partners in the project. One withdrew at an early stage, which left the following four:

- The Abbeyfield Society, which operates over 500 care homes mainly in the UK. Although they sit within the Abbeyfield Society group, each home is an organisation in its own right.
- The Methodist Homes Association, whose social licence was targeted at the Live at Home schemes that support people, including those living with dementia, to live independently in their own homes. There are over 70 Live at Homes Schemes nationwide and over 4,000 volunteers in this network.
- The Conservation Volunteers, who organise a range of activities delivered by volunteers, across the UK, with the aim of getting disadvantaged people outdoors in order to improve the health and wellbeing, re-engage with the community and learn new skills. Their highly successful Green Gym programme provides free outdoor exercise classes. The ethos of TCV is to ensure the Green Gyms are inclusive and accessible to all so that the participants reflect the whole spectrum of the local community: old, young, working, retired, unemployed and people living with dementia.
- Care Farming UK, a care farmer-led charity. Care Farming is the therapeutic use of farming practices and care farms to provide health, social or educational care services for individuals from one or more of a range of vulnerable groups. It was anticipated that the social licence would enable Dementia Adventure to work with the Care Farming UK as the lead organisation and deliver training and support to care farmers across the UK, using the blended learning approach.

Each of these four delivery partners committed to identifying a minimum of 8 delegates across the organisation, enabling the work to be piloted in over 40 localities. Training was to be cascaded to a maximum of 50 further staff and volunteers through a mixture of blended on and offline method of delivery and via the licenced delegates. Each organisation aimed to implement and establish a programme of regular outdoor activities that would leave a legacy of support for people living with dementia. They also agreed to provide sufficient evaluation data sets in order to learn, adapt, and collate evidence to support a sustainable licence model.

This document was written by the evaluation team to provide a final report on the evaluation of Dementia Adventure in a Box and highlight key learning to inform the initiative going forwards.

3. The Evaluation

The evaluation was led by the Association for Dementia Studies (ADS) at the University of Worcester, drawing on their substantial expertise in research and evaluation focusing on maximising quality of life of people living with dementia, with specialist support from the Green Exercise Research Team at the University of Essex.

The Association for Dementia Studies is a centre for excellence in research and education based at the University of Worcester. Our overarching aim is to make a cutting-edge contribution to developing evidence-based practical ways of working with people living with dementia, their families, friends and carers that enable them to live well. We have substantial research experience across a range of topics including early interventions and primary care, living well with dementia, supporting choice and control at home and in supported housing, dementia-friendly hospital care, dementia and the arts and person-centred care in care homes. The core philosophy of ADS is predicated on collaborative working and strong engagement with people living with dementia and family carers across all of our activities.

The Green Exercise Research Team at the University of Essex has been researching the role of nature and greenspace experiences for health and wellbeing impacts, and specifically the concept of green exercise, since 2003, and is a leader in this area. The Green Exercise Research Team comprises experts in the areas of exercise physiology, psychology, health and wellbeing, environmental sustainability, community engagement and behaviour change. The team has published a number of commissioned evaluative reports on the impacts of green care and other environment-based intervention programmes that are run for vulnerable groups, by organisations such as The Wildlife Trusts, The RSPB, The National Trust, Mind, TCV, Natural England and the Wilderness Foundation.

Evaluation Methods

The evaluation adopted a mixed methods approach in order to assess the impact of the social licence pilot and its' overarching aim to give people living with dementia opportunities and support to access the natural environment, leading to improved health and wellbeing. The evaluation was commissioned to measure progress against the project aims and to explore in detail the process of implementation with project partners and individual delegates, the outdoor activities they provided and the resulting impacts on people living with dementia and their carers. A range of core project outcomes, indicators and targets were agreed in the form of an evaluation framework, as shown in Figure 1 below.

| Outcome | Indicator: describe indicator and how you'll know you are achieving this outcome | Indicator Level: What amount of change do you expect to see | Timescale: When will this amount of change happen by |
|--|--|---|--|
| 1. The creation and development of a strong network of partners who can work together to increase the supply of nature-based adventures | (i) Number of licenced partners | 5 (partner organisations) | End of years 1,2,3 |
| | (ii) Number of delegates trained | 40 (8 per partner organisation) | End of years 1,2,3 |
| | (iii) Number of locations (of delegates) | 40 (each delegate working in a unique location/postcode) | End of years 1,2,3 |
| 2. Increase in delegates understanding of dementia and confidence in using nature based approaches in supporting people to live well with dementia | (i) Delegate dementia awareness/knowledge | An average 10-point improvement in the Dementia Knowledge Assessment Scale | End of years 1,2,3 |
| | (ii) Delegate confidence | Improvement on bespoke DA 0-10 scale | End of years 1,2,3 |
| | (iii) Delegate satisfaction | An average 10-point improvement in Generic Job Satisfaction scale | End of years 1,2,3 |
| 3. Increase in local provision of 'dementia friendly' or 'dementia inclusive' outdoor activities and in the number of people with dementia taking part | (i) Number of outdoor activities | 12 per delegate per year (starting after first six months of training) CALC: (12 activities x 40 delegates = 480) x 3 years = 1200 (NB: Y1 50%) | End of years 1,2,3 |
| | (ii) Number of people taking part | Per delegate: 24 unique individuals per year and (x%) regular activity participants (regular activity participation = participation in more than x% of activity sessions offered by a given partner) CALC: (24 people x 40 delegates = 960) x 3 years = 2400 (NB: Y1 50%) | End of years 1,2,3 |
| | (iii) Range of outdoor activities | We expect to see a diverse range of offered outdoor activities. Thematic categorisation of activities, subsequent to data collection, will identify trends | End of project |
| 4. Maintained/improved wellbeing for people taking part in regular activities | (i) Self-reported wellbeing | Stability or improvement in SWEMWBS score for people with dementia; reflective indication via qualitative interviews with people with dementia | End of year 2 and 3 |
| | (ii) level of physical activity | (a) Self-reported decreases in sedentary behaviour and inactivity levels (b) Number of participants achieving 150-minutes of moderate to vigorous physical activity per week, as assessed from people with dementia and carers via interviews and surveys | End of year 2 and 3 |
| | (iii) Carer coping | Improvement in Abbreviated COPE score and reflective indication via interviews | End of year 2 and 3 |

Figure 1. The evaluation framework

The evaluation team developed an approach and collated a range of tools to be used in order to assess progress against each outcome, as follows.

For people living with dementia and family carers taking part in activities delivered by the project:

- The Shorter (7 point) Warwick-Edinburgh Mental Wellbeing scale¹ (SWEMWBS), which was developed to enable the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing;
- A single-item self-report measure of physical activity (how many physically active days per week);
- COPE², a multidimensional coping inventory to assess the different ways in which people respond to stress. The abbreviated version has 26 items (see Appendix Two).

These tools were to be administered by project delegates and returned to the evaluation team for analysis and reporting.

For delegates from partner organisations who delivered project activities:

- The Dementia Knowledge Assessment Scale³, developed to assess knowledge deficiencies and change in those who provide care and treatment for people with dementia;
- The Generic Job Satisfaction Scale⁴, designed for use in a wide range of occupational groups;
- A series of questions from the Dementia Adventure training evaluation form (see Appendix Three) exploring delegate confidence e.g. feeling able to plan nature experiences, knowing about the range of wellbeing benefits associated with access to nature and outdoor experiences.

These tools were to be administered by Dementia Adventure at training sessions and returned to the evaluation team for analysis and reporting. In addition, partner organisation leads and individual delegates were required to return regular delivery logs (see Appendix Four), recording a range of data including number of activities,

¹ <http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/>

² <http://www.psy.miami.edu/faculty/ccarver/sclCOPEF.html>

³ <https://www.ncbi.nlm.nih.gov/pubmed/26503020>

⁴ http://anthro.vancouver.wsu.edu/media/Course_files/anth-260-edward-h-hagen/job_staisfaction_1997-libre.pdf

activity type/category, activity duration, activity intensity and number of participants.

Developments during the project led to two changes being made to the methods used. Firstly, due to concerns raised by Dementia Adventure during the project set-up stage about the wording of some items in COPE, this measure was withdrawn from the study and it was decided instead to use the SWEMWBS as a measure of the project's impact on carers. Secondly, concerns were raised by project stakeholders about using the SWEMWBS in the project. These concerns focused on the wording of items around happiness, feeling worthwhile and looking to the future, which it was felt could be confusing or distressing for some people living with dementia. As a result, and in collaboration with a Special Interest Group of people affected by dementia that supported the project, we developed a revised version of the measure which aimed to be more accessible for people living with dementia (Appendix X). Because it was introduced after the evaluation had started, it was based on the same scoring system so that both versions of the measure could be analysed together.

In-depth case study work was carried out by the evaluation team across a sample of participating organisations to allow a more detailed analysis of progress against the overarching project aims, including facilitators and barriers associated with DAiAB implementation and the nuanced impacts for participants. Data were collected in the following ways:

For participants in the activities (people with dementia and family carers) –

- self-reported wellbeing was measured using the Warwick-Edinburgh Mental Wellbeing Scale;
- research interviews were used to explore their experiences of taking part in DAiAB activities including the perceived impacts and any enablers or barriers to taking part;
- a small sub-sample of participants were invited to wear physical activity monitors (ActiGraph accelerometers) for a week at a time. The aim was to monitor the extent that Dementia Adventure activities might contribute to and impact on weekly physical activity levels. It was also intended that this element of the evaluation would offer a valuable opportunity to pilot the use of physical activity trackers with people living with dementia.

For provider organisation staff delivering and managing the activities –

- research interviews were used to gather information about their experiences of staff and co-ordinators taking part in the DAiAB project, including facilitators and barriers.

In addition to the location-based case studies, we collected a substantial amount of data through pre-arranged telephone interviews with four delegates (three from MHA and one from SF&G) and two provider leads (MHA and SF&G), an extra visit to one SF&G location to offer advice/support with the evaluation, regular telephone and email communications with DAiAB delegates throughout the project, an online forum for delegates, and researcher field notes.

In order to capture additional data about the activities from delegates, in particular from those who were not engaging with the formal evaluation process, a short online survey was created and circulated. Delegates were invited to complete the survey as often as they wished and provide qualitative data that might otherwise have been missed.

Additionally, when contacting delegates to prompt them for updates and information about their activities, further details emerged relating to how different aspects of the project had been progressing.

Evaluation training and support

As part of their commitment to the project, the partner organisations had agreed to 'The collation of sufficient evaluation data sets in order to learn, adapt, and collate evidence to support a sustainable licence model'. To facilitate this activity, the evaluation team provided the evaluation packs and took part in the main delegate training sessions by presenting a summary of the evaluation methods and materials, and answering any questions that arose. However, it soon became apparent when the project started that the evaluation approach presented challenges for many delegates. For example, some delegates felt that the evaluation forms were too complex for participants, and many lacked facilities to print them off locally. It soon became apparent that delegates were time poor, and no administration time had been built in on top of activity delivery. As a result, the evaluation team received limited information about activities that were delivered as part of the project and fewer than expected evaluation forms that had been completed by participants in activities. In order to rectify this situation, the evaluation team devised and implemented a schedule for making regular contact with all delegates by email and telephone in order to gather intelligence about planned activities and encourage delegates to use the evaluation tools. We also developed a series of short videos about various aspects of the evaluation (e.g. how to gain consent; completing the evaluation forms) and took part in two webinars that focussed on the evaluation. In addition, a dedicated email support address was set up for providers and delegates to use as a direct contact with the evaluation team, and several visits were made to specific delegates who appeared to be struggling with implementing the evaluation tools. Together, these measures did contribute to an increase in returns of evaluation forms and in information about activities that were planned. However,

these challenges led to negativity among some delegates, who felt they had no opportunity to contribute towards an evaluation design that was not easy to apply in practice. Overall, there was a missed opportunity to consider co-design during the project planning stage.

Evaluation reporting

Progress with the evaluation was reported via six-monthly and annual evaluation reports, culminating in this final report. In addition, evaluation team leads from the Universities of Worcester and Essex held bi-monthly video catch ups with the Dementia Adventure project co-ordinator. The evaluation team in its entirety held several face-to-face meetings at key points in the evaluation and maintained regular contact through online meetings, emails and telephone calls.

4. Evaluation Findings

4.1 Evaluation of the Dementia Adventure training programme

Training delivery

The evaluated training programme consisted of five individual days, each with a different focus as follows:

- Day One – Thinking differently about dementia
- Day Two – Risky business
- Day Three – Creating outdoor experiences
- Day Four – Nature in mind
- Day Five – Train the trainer

These days were delivered over a 20-month period on multiple occasions in various locations in order to reach as many delegates as possible. A total of 29 sessions were evaluated, as shown in Table 1.

Table 1: Overview of sessions run as part of the evaluated training – topics and indicative delivery period

| Session topic | No. sessions evaluated | Delivery period | | | | | | | | | | | | | | | | | | | |
|-------------------------------------|-----------------------------|-----------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| | | Oct 2017 | Nov 2017 | Dec 2017 | Jan 2018 | Feb 2018 | Mar 2018 | Apr 2018 | May 2018 | Jun 2018 | Jul 2018 | Aug 2018 | Sep 2018 | Oct 2018 | Nov 2018 | Dec 2018 | Jan 2019 | Feb 2019 | Mar 2019 | Apr 2019 | May 2019 |
| Thinking differently about dementia | 9 (inc. one online session) | | | | | | | | | | | | | | | | | | | | |
| Risky Business | 6 | | | | | | | | | | | | | | | | | | | | |
| Creating Outdoor Experiences | 5 | | | | | | | | | | | | | | | | | | | | |
| Nature in Mind | 5 | | | | | | | | | | | | | | | | | | | | |
| Train the Trainer | 4 | | | | | | | | | | | | | | | | | | | | |

Training reach

The number of delegates trained

The evaluation framework for the project included a target for delegates based at 40 locations to receive training (8 in each of the five provider organisations). Given that one provider organisation withdrew from the project at a relatively early stage, for the purposes of this report the target has been revised to 32 locations.

Training evaluation forms were completed by 68 delegates, most of whom attended part of the training programme rather than the full five days. As Table 2 shows, only Days 1 & 2 were attended by more than 32 delegates, and a total of 11 delegates attended all five training days. Of the 68 delegates, 58 gave consent for their completed forms to be included in the evaluation.

Table 2: Delegates from each organisation on the five training days (based on the number of evaluation forms received)

| | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Total days by provider | Attending all five days |
|-----------------------------|-----------|-----------|-----------|-----------|-----------|------------------------|-------------------------|
| The Abbeyfield Society | 7 | 6 | 1 | 6 | 1 | 21 | 1 |
| Social Farms & Gardens | 11 | 15 | 10 | 9 | 6 | 51 | 3 |
| MHA | 13 | 10 | 7 | 8 | 9 | 37 | 4 |
| Provide CIC* | 7 | - | - | - | - | 7 | 0 |
| The Conservation Volunteers | 8 | 8 | 6 | 6 | 6 | 34 | 3 |
| Total | 46 | 39 | 24 | 29 | 22 | | 11 |

* Provide CIC withdrew from the project at an early stage.

In order to accommodate delegates who had not attended initial training or who had joined the project after the bulk of the training programme had been delivered, additional one-off training days were delivered by Dementia Adventure. As the format for these days was substantially different from the core training programme, they were not included in the evaluation. It can be seen from Table 3 that a similar number of people were trained on these additional training days as across the whole five-day training programme. Overall, a total of 132 delegates received some form of training from Dementia Adventure.

Table 3: Delegates trained during additional one-off training days (not evaluated)

| | Number of delegates who attended training |
|-----------------------------|--|
| The Abbeyfield Society | 12 |
| Social Farms & Gardens | 41 |
| MHA | 9 |
| Provide CIC | - |
| The Conservation Volunteers | 2 |
| Total | 64 |

The number of delegate locations

Another key target for the project was to have delegates working in a minimum of 40 unique locations. This has been revised to 32 locations on a pro rata basis for the purposes of this evaluation, due to the withdrawal of Provide CIC. Delegate turnover and varying levels of engagement have presented challenges in terms of keeping track of the locations involved in the project. For example, some delegates formally withdrew from the project while others did not respond to repeated attempts to contact them. Table 4 presents our final understanding of locations, indicating that although the total number of locations involved across the lifetime of the project exceeded the target, the number of locations involved at the end of the project is only 75% of the revised target.

Table 4: Summary of locations involved per organisation

| | No. of locations involved at some point | No. of locations with multiple delegates during project* | No. of locations still involved at end of project |
|-----------------------------|--|---|--|
| The Abbeyfield Society | 9 | 3 | 2 |
| Social Farms & Gardens | 10 | 1 | 7 |
| MHA | 12 | 6 | 11 |
| The Conservation Volunteers | 13 | 5 | 4 |
| Total | 44 | 15 | 24 |

*Reasons included delegates leaving their organisation, going on maternity leave, and more than one person working on the project at the same time

Training impact

The training programme had the overall aim of increasing delegate understanding of dementia and their confidence in using nature-based approaches to support people to live well with dementia. Three measures were used to assess the extent to which this was achieved: The Dementia Knowledge Assessment Scale; a bespoke delegate confidence scale; and the Generic Job Satisfaction Scale.

Delegate dementia awareness and knowledge

Dementia awareness was measured using the Dementia Knowledge Assessment Scale (DKAS), which is a 27-item scale looking at what people know about the most common forms of dementia. Any delegate who missed out more than two questions was excluded from the analysis to avoid their scores artificially skewing the results. Possible total scores for the DKAS range from 0 to 54, and the project target for this impact was an average 10-point improvement.

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Due to the number of delegates attending the different training days, the DKAS scores were evaluated in two ways. Firstly, looking at the impact of the first training day, focusing on delegates who had a DKAS score captured at both the beginning (pre) and end (post) of the day. Secondly, looking at the impact of the whole training

programme, focusing on delegates who attended all five days and comparing their DKAS scores at the beginning and end of the whole course.

It can be seen that after the first training day the DKAS scores had significantly improved across all eligible delegates, and also when the Provide CIC delegates had been excluded from the analysis (Table 5). The average improvement was less than the target of 10 points, but was statistically significant. When considering the smaller group of delegates who completed the whole five-day programme, the improvement in DKAS scores was also statistically significant, and the average improvement was greater than the target increase at 13.2 points (Table 6).

Table 5: Impact of the first training day – dementia knowledge

| | |
|---|--|
| All delegates with a pre and post DKAS score who consented to be part of the evaluation (n=41) | Mean score increased from 34.2 to 41.2 out of a possible 54 (statistically significant improvement p=-0.00001) Average increase of 7 points (20% improvement) |
| Excluding Provide CIC delegates (n=34) | Mean score increased from 35.1 to 41.3 (statistically significant improvement p=-0.0003) Average increase of 6.1 points (17% improvement) |

Table 6: Impact of the five-day training programme – dementia knowledge

| | |
|--|--|
| All delegates with a pre and post course DKAS score who consented to be part of the evaluation (n=10) | Mean score increased from 30.0 to 43.2 (statistically significant improvement p=-0.002) Average increase of 13.2 points (44% improvement) |
|--|--|

Delegate confidence in using nature-based approaches

Delegates were asked to rate themselves on a 1-10 scale in five areas relating to connecting with nature and outdoor experiences. The target impact was to see an improvement in confidence. Again, the scores were considered for the first training day (with and without the Provide CIC delegates) and for the five-day training course as a whole.

After the first training day there was an increase across all five areas, both when including and when excluding the Provide CIC delegates. In many cases the improvement was statistically significant, but for the statement relating to confidence the observed improvement was not statistically significant. When considered across the whole five-day training course an improvement was seen in four of the five areas, and the improvement in confidence was statistically significant in three areas (Table 7).

Table 7: Impact of the first training day – confidence

| | All delegates with a pre and post score who consented to be part of the evaluation (n=41) | Excluding Provide CIC delegates (n=30) |
|---|---|---|
| I know about the range of wellbeing benefits associated with access to nature and outdoor experiences | Mean score increased from 8.0 to 8.9 (significant improvement CI=0.05, p=-0.02) Average increase of 0.9 points (11% improvement) | Mean score increased from 8.1 to 9.0 out of a possible 10 (significant improvement p=-0.03) Average increase of 0.9 points (11% improvement) |
| I know how to access research and other resources to increase connection to nature and plan outdoor experiences | Mean score increased from 6.7 to 8.3 (significant improvement CI=0.05, p=-0.000001) Average increase of 1.7 points (25% improvement) | Mean score increased from 6.6 to 8.3 (significant improvement p=-0.00002) Average increase of 1.7 points (25% improvement) |
| I am confident in using risk/benefit assessment in my own role to encourage contact with nature and experience of the outdoors | Mean score increased from 7.2 to 7.6 (not significant CI=0.05, p=-0.09) Average increase of 0.4 points (6% improvement) | Mean score increased from 7.3 to 7.7 (not significant p=-0.2) Average increase of 0.4 points (5% improvement) |
| I want to be a 'nature advocate' and share the benefits of outdoor nature experiences with my colleagues (and seek their involvement) | Mean score increased from 8.2 to 8.8 (significant improvement CI=0.05, p=-0.03) Average increase of 0.6 points (7% improvement) | Mean score increased from 8.4 to 9.0 (significant improvement p<-0.05) Average increase of 0.6 points (8% improvement) |
| I feel able to plan nature experiences which can be personalised for each individual | Mean score increased from 7.2 to 7.7 (not significant CI=0.05, p=-0.08) Average increase of 0.6 points (8% improvement) | Mean score increased from 7.4 to 7.8 (not significant p=-0.3) Average increase of 0.5 points (7% improvement) |

Table 8: Impact of the five-day training programme – confidence

| | All delegates with a pre and post course score who consented to be part of the evaluation (n=10) |
|---|---|
| I know about the range of wellbeing benefits associated with access to nature and outdoor experiences | Mean score increased from 7.8 to 9.1 (not significant p=-0.7) Average increase of 1.3 points (17% improvement) |
| I know how to access research and other resources to increase connection to nature and plan outdoor experiences | Mean score increased from 6.0 to 9.2 (significant improvement p=-0.008) Average increase of 3.2 points (53% improvement) |
| I am confident in using risk/benefit assessment in my own role to encourage contact with nature and experience of the outdoors | Mean score increased from 7.1 to 9.1 (significant improvement p=-0.004) Average increase of 2.0 points (28% improvement) |
| I want to be a 'nature advocate' and share the benefits of outdoor nature experiences with my colleagues (and seek their involvement) | Mean score decreased from 8.5 to 8.3 (not significant p=-1.3) Average decrease of 0.2 points (2% decline) |
| I feel able to plan nature experiences which can be personalised for each individual | Mean score increased from 6.9 to 9.1 (significant improvement p=-0.02) Average increase of 2.2 points (32% improvement) |

Delegate satisfaction

The target for this training impact was an average 10-point improvement on the Job Satisfaction Scale, where the range of possible scores is 10-50. As this was only captured at the end of a training day, changes across the whole five-day training course were assessed first; the sample size was relatively small comprising only seven delegates with valid scores (i.e. they responded to at least nine of the ten statements on the scale) at both the start and end of the whole five-day course. For this group the mean satisfaction score decreased from 40.1 to 35.7 (out of a possible 50), an average of 4.4 points. Although surprising, this decrease was not statistically significant ($p=-0.5$), and it should be noted that this score is contributed to by all aspects of the delegates' jobs – not simply their involvement in this project.

When looking at the responses in more detail (Figure 2 and Figure 3), at the start of the course the areas rated less positively were those relating to feeling valued, such

as wages, receiving recognition, job security and management showing concern. Although all areas saw a decline, those relating to feeling valued were still the ones rated least positively. It is also interesting to note that despite the decline, very few responses were 'strongly disagree'.

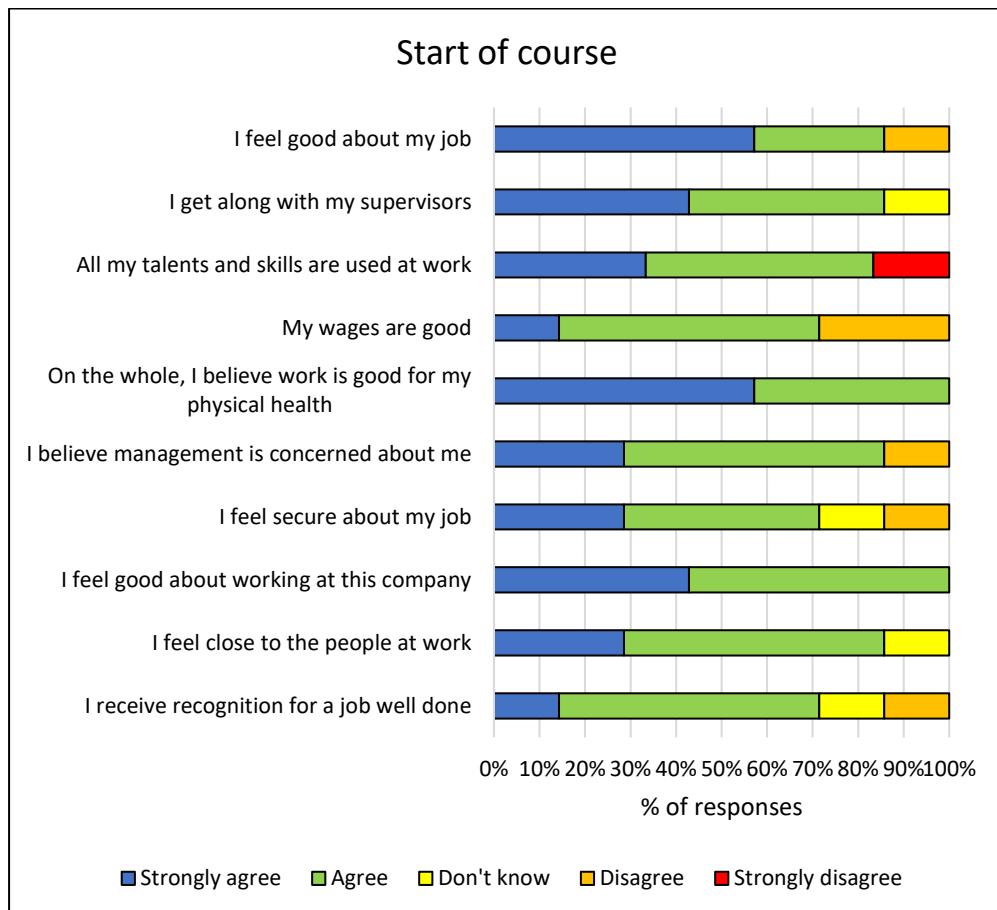


Figure 2: Satisfaction at the start of the course

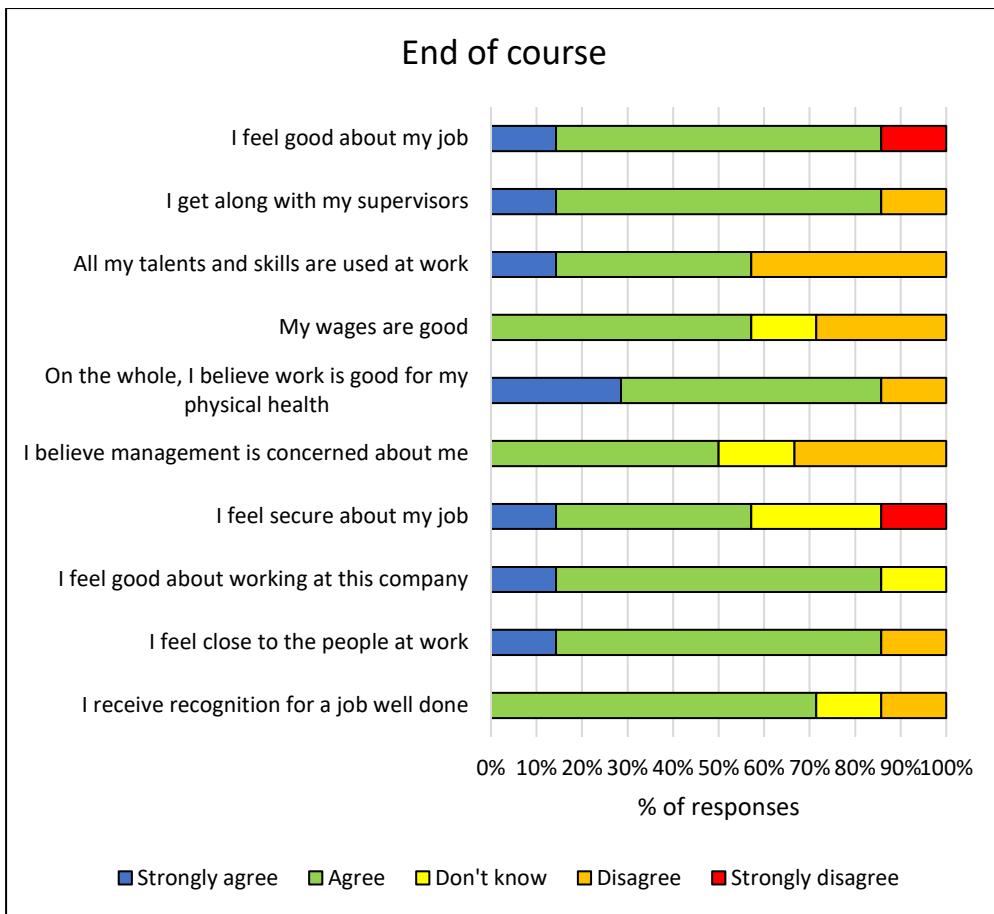


Figure 3: Satisfaction at the end of the course

In order to increase the sample size, the criteria for inclusion was then expanded to include all delegates who completed the measure and obtained a valid score on Day 1 and at least one other day. The latest day with a valid score was used for each delegate. This resulted in a group of 23 delegates. For this group the mean satisfaction score decreased slightly from 39.0 to 37.8, but again this decrease was not statistically significant ($p = -0.4$).

When looking at the responses for this larger group in more detail (Figure 4 and Figure 5), at the start of the course the areas rated less positively were again those relating to feeling valued, such as wages, receiving recognition, job security and management showing concern. Almost all areas saw a decline, although as the responses shown in Figure 4 were captured on different days for different delegates it is not easy to get a clear picture of the overall impact.

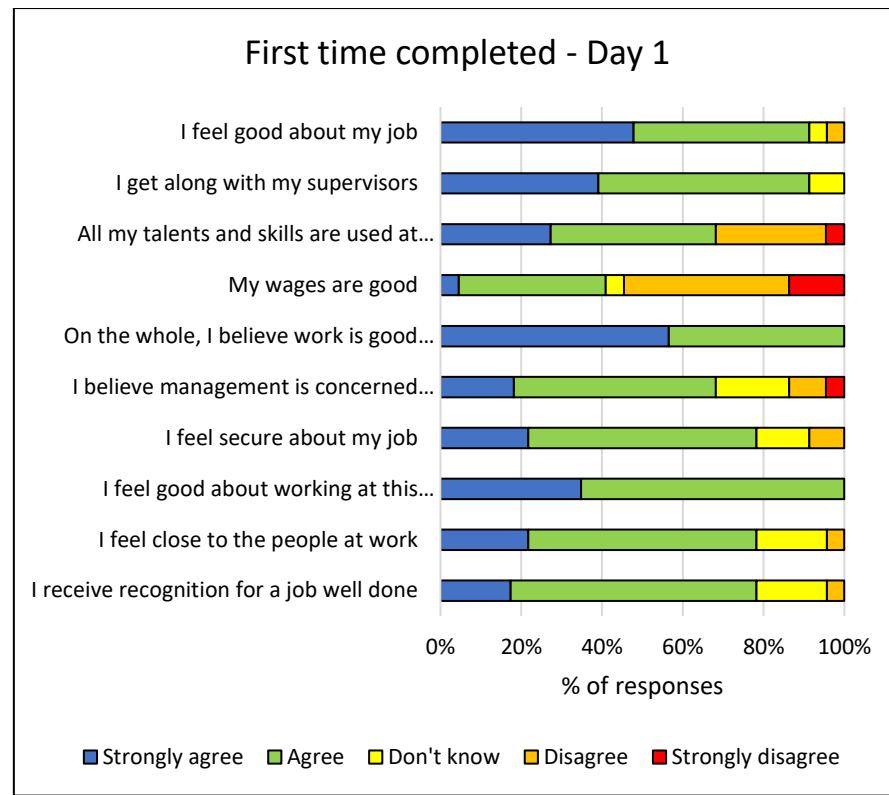


Figure 4: Satisfaction on Day 1

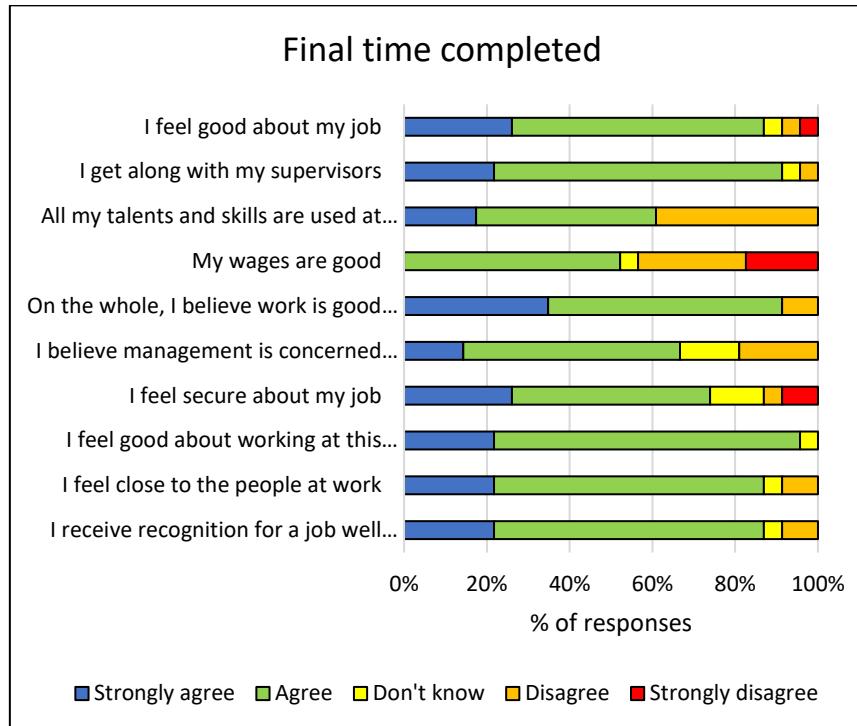


Figure 5: Satisfaction on last day completed

Feedback on the training

Additional feedback about the training was obtained using a combination of qualitative and quantitative questions. These were completed by varying numbers of delegates each day as shown in Table 9.

Table 9: Delegates providing training feedback each day

| | Delegates completing feedback forms | | | | |
|--------------------------------------|-------------------------------------|-------|-------|-------|-------|
| | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 |
| All delegates who gave consent | 41 | 37 | 21 | 25 | 15 |
| Delegates who attended all five days | 10 | 10 | 9 | 10 | 10 |

Recommending the training

The training days were positively received, with all delegates who completed the evaluation forms and consenting to be part of the evaluation saying that they would recommend each of the days they attended. This equated to 100% of a total of 139 forms.

Programme meeting its objectives

100% of delegates who attended a day and consented to be part of the evaluation also said that they felt each day had met its objectives (n=139).

Relevant content

100% of delegates who attended at least one day and consented to be part of the evaluation also said that they felt the content was relevant on each day (n=139).

Qualitative feedback indicated that delegates felt that Day one improved their dementia knowledge and gave them new ideas and a better understanding of needs, while they also liked the discussions and ability to network with other delegates. Day two gave them an increased understanding and boosted their confidence by enabling them to exchange ideas and participate in example activities, especially those that involved going outside. Similarly, the ability to do practical outdoor exercises on Days three and four was appreciated, along with further opportunities to share ideas and experiences. Also, on Day four, delegates felt that the training gave them more awareness of the challenges that people with dementia may face. In relation to Day five, delegates reported that they particularly appreciated the opportunity to meet a person living with dementia, and being able to give their own presentation.

Skill of the trainers

The vast majority of delegates rated the skill of the trainers as ‘Excellent’ on each of the five training days (Figure 6), with a minimum of 78% (Day 1, n=41) and an average of 87%. Only one delegate across the five days rated the trainers as ‘Not very good’, but no further information was provided to explain their choice.



Figure 6: Rating the skill of the trainers each day

For the group of 10 delegates who attended all five days and were part of the evaluation, the ratings were slightly more positive with 80% rating the trainers as ‘Excellent’ (Day 1), and an average of 90%. No delegates reported trainers to be ‘Not very good’.

Training aids

A similar pattern was seen regarding the delegates rating the training aids (e.g. handouts, slides, resources) each day, although the proportion of ‘Excellent’ ratings was slightly lower across the board than for the trainer skills (Figure 7). The minimum ‘Excellent’ rating was seen on Day 4 at 58% (n=25), while the average across all five days was 69%. Again, no further information was given by the one delegate who gave a ‘Not very good’ rating.

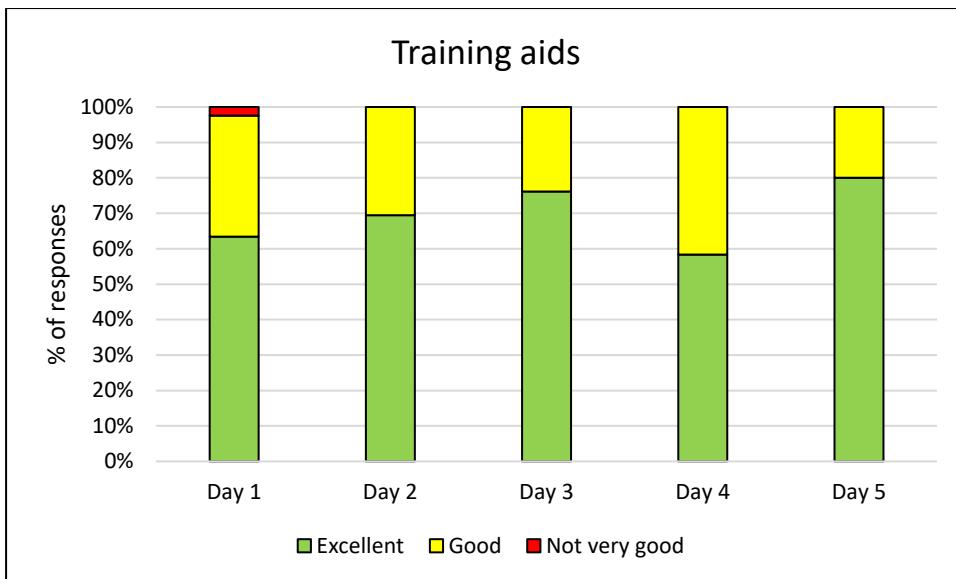


Figure 7: Rating the training aids each day

Of the 10 delegates who attended all five days and were part of the evaluation, 60% rated the training aids as ‘Excellent’ (Day 4) with an average of 73% across the five days, again making them slightly more positive than the wider group of delegates. No-one felt that they were ‘Not very good’.

Course rating

The average course rating (out of a possible 10) given by all delegates in the evaluation across a total of 139 forms was consistently high for each of the five training days (Figure 8). The lowest rating on any day was a 7 given by one delegate on Day 1, who commented that because the projects had not been fully arranged at that point, the training felt “*partly like a consultation session*”. The main suggestion given about improving the training course indicated that the delegates wanted the training days closer together.

The average course rating by delegates who attended all five days was similarly very high.

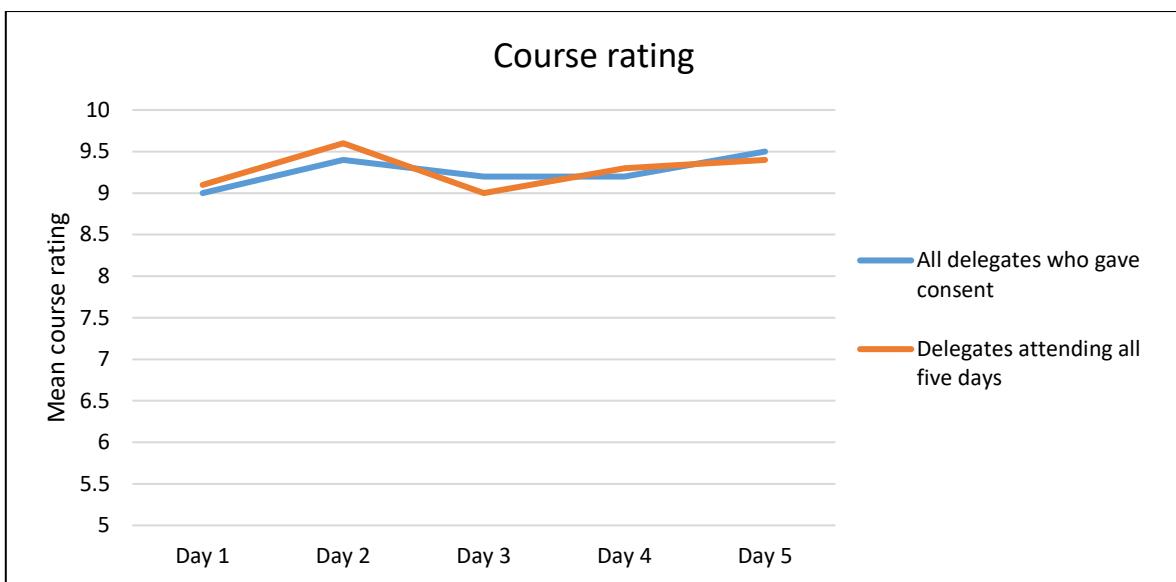


Figure 8: Average (mean) course ratings

Summary

29 'core' training days were evaluated by 68 delegates plus 64 additional stand-alone days. 11 delegates attended all 5 training days

The training days were positively received and highly rated. All delegates who completed the evaluation forms said that they would recommend each of the days they attended, that each day had met its objectives and that the content was relevant. Pre- and post-training measures indicate that it was associated with increased understanding of dementia among delegates and confidence about working with people living with dementia. Self-reported job satisfaction was slightly lower after the training.

Training took place over a long period of time, with significant time elapsing between sessions. As a result, staff turnover among the delegates during this period meant that only 11 delegates completed all five days of training. It also meant that delegates were required to organise, deliver and evaluate activity sessions before they had completed the full 5-day training programme. Many delegates appeared reluctant to start delivering sessions until they had been on at least a few of the training days.

4.2 The DAiAB activities

Keeping track of the activities that were organised and evaluated by the delivery partners required regular contact with individual delegates. This was complicated by a number of factors:

- Locations with more than one delegate working on the project at the same time, especially if there was no clear ‘lead’;
- Delegates leaving their respective organisations;
- Delegates going on maternity leave, although this was generally communicated in advance
- Delegates no longer being involved in the project;
- A lack of engagement from delegates, especially in terms of responding to contact from the evaluation team;
- Inconsistent support from the co-ordinators for each organisation, requiring the evaluation team to have more direct contact with delegates than initially anticipated.

According to the information that we collected, there were a total of 64 delegates involved in activities across 44 locations; of these, 5 delegates left their organisation and were replaced (this includes two who went on maternity leave); 5 delegates left and were not replaced; 15 ended their involvement in the project for unspecified reasons.



Wellbeing Walks

RSPB St Aidan's Nature Park,
Astley Lane, Leeds LS26 8AL

Walks are on the last Wednesday of each month:

27th March, 24th April, 29th May, 26th June 2019.
Meeting at St Aidan's Visitor Centre
at 11.00am

These monthly walks, accompanied by RSPB Volunteer Rangers, are no more than one mile and last for about an hour. The walks are open to all, especially older people and are dementia friendly. A gentle sociable stroll, aimed at those wanting to be outside, enjoy what St Aidan's Nature Park has to offer and to improve their physical and mental wellbeing.

No booking needed, just turn up!
(Walks will be subject to weather conditions)

Find out more at St Aidan's Nature Park.
Tel: 0113 232 0529
The RSPB is a registered charity in England & Wales 207078 & Scotland SC039844

In most cases the evaluation team was only aware of a change in delegate after it had happened, often finding out when efforts to contact a delegate failed and relying on updates from Dementia Adventure to discover who the new delegate was. Not all delegates were replaced if they left the project; and when they were replaced, the lack of consistency often impacted on communication and engagement with the evaluation team. It was not always clear whether new delegates had a comprehensive handover from their predecessors, but attempts to contact new delegates to engage them with the evaluation at an early stage were less successful

than hoped on many occasions. Some new delegates appeared unaware of the project and/or the evaluation.

Delegates per provider organisation

The Abbeyfield Society

- 14 delegates were named during the evaluation period across 9 locations;
- 3 locations had 2 delegates each;
- 2 delegates left the organisation and were replaced;
- 6 delegates were no longer involved for unspecified reasons (this was communicated to the evaluation team by the delegate or by Dementia Adventure).

Social Farms & Gardens

- 12 delegates were named during the evaluation period across 10 locations;
- 1 location had 2 delegates;
- 1 delegate left the organisation and was replaced;
- 1 location withdrew for an unknown reason;
- 2 delegates were no longer involved for an unspecified reason (this was communicated to the evaluation team by the delegate or by Dementia Adventure).

MHA

- 18 delegates were named during the evaluation period across 12 locations;
- 2 locations had 2 delegates each;
- 2 delegates left the organisation and were replaced;
- 2 delegates went on maternity leave and were replaced;
- 1 delegate was no longer involved for an unspecified reason (this was communicated to the evaluation team by Dementia Adventure).

The Conservation Volunteers

- 20 delegates were named during the evaluation period across a maximum of 13 locations, although 4 were identified by Dementia Adventure and it was not clear if they were actually involved in the project;
- 5 locations had 2 or more delegates each;
- 5 delegates left the organisation and were not replaced;
- 5 delegates were no longer involved for an unspecified reason (this was communicated to the evaluation team by the delegate or by Dementia Adventure).

Despite these fluctuations, several delegates engaged well with the evaluation team, providing regular information and additional feedback when requested, and returning completed evaluation forms when possible.

Overview of activities delivered

As part of the evaluation process it was intended that the provider co-ordinators would collate information from their respective delegates regarding the activities they had delivered and submit this summary to the evaluation team on a monthly basis.



Unfortunately, this did not transpire in a systematic way, so it fell to the evaluation team to try and contact each delegate individually at regular intervals to get updates of activities. While some information was forthcoming from the completed evaluation forms and a handful of delegates, this exercise was not straightforward. High staff turnover and a lack of engagement from some delegates meant that just knowing who to contact was an issue for the evaluation team. This was compounded by delegates not always distinguishing between DAiAB activities and other activities that they delivered within their job role, and providing limited information to clarify who was involved.

Consequently, the following information is based on the evaluation team's understanding of the activities delivered by delegates, which were attended by at least one person with dementia.

Variety of activities

As a variety of different types of activity were delivered and reported, they have been classified according to a set of simple criteria in order to provide an overall summary. The criteria were:

- Does the activity take place indoors or outdoors?
- Is the activity nature-based or not?

Where limited information was available and further detail could not be obtained (e.g. by conducting an internet search of a destination), a best guess has been made.

Additionally, some activities are classed as ‘one-off’ sessions while others form part of an ongoing series that tended to take place on a regular basis. Figures for both types of activity are provided in Table 10 below.

Some activities were specifically for people with dementia, such as dementia cafés and additional care farm days, while others were open to all to attend, including people with dementia. This included many outings, visits and walks. Additionally, some activities were newly-developed directly as a result of the DAiAB project (e.g. intergenerational woodland sessions, some care farm days), while others were existing activities where delegates made more of an effort either to encourage attendance by people with dementia or to make it more nature-based (e.g. monthly outings, some care farm days, animal or gardening sessions at a dementia café).

In some cases, the provision of activities was influenced by organisational factors. For example, many MHA Live at Home schemes have large cohorts of members comprising people with and without dementia, so in many cases running sessions just for people with dementia was not a viable option. Similarly, Abbeyfield activities were likely to be available to all care home residents, not just those with dementia.

Activity participants

Accurate data regarding numbers of participants was not always available, but the figures shown below indicate that the activities delivered within DAiAB project have reached a substantial number of people. In some cases it is known that people with dementia went to multiple activity sessions, particularly when they were part of a series. For example it is known that three individuals accounted for 355 attendances at one care farm. Similarly:

- 243 attendances at another care farm relate to a pool of approximately 7 individuals;
- 236 attendances at a ‘chit chat’ group are likely to be by the same pool of 6 individuals;
- 336 attendances at a singing for wellbeing group are likely to be by the same 3 individuals;
- 53 attendances at both a woodland group and a nature walk relate to the same pool of approximately 5 individuals.

| | Indoors | Outdoors | Totals |
|-------------------------|--|--|--|
| Nature-based | <ul style="list-style-type: none"> • 31 one-off sessions • 24 sessions that are part of 5 different activity series <p>E.g. donkey visit to care home, making bird feeders at a 'chit chat' group, flower arranging at a café group</p> | <ul style="list-style-type: none"> • 69 one-off sessions • 512 sessions that are part of 16 different activity series <p>E.g. nature walk, farm activities, visit to garden centre, visit to house and gardens, visit to the beach, woodland activities, gardening</p> | 636 individual sessions comprising: <ul style="list-style-type: none"> • 100 one-off sessions • 536 sessions as part of 21 different activity series |
| Not nature-based | <ul style="list-style-type: none"> • 38 one-off sessions • 209 sessions that are part of 10 different activity series <p>E.g. dementia friendly cinema, music and memories, singing for wellbeing, unspecified 'chit chat' session, poetry at a café group, pub lunch, museum visit, bowling</p> | <ul style="list-style-type: none"> • 26 one-off sessions • 4 sessions that are part of 2 different activity series <p>E.g. walk to a high street, outing to a town, visit to a fair/fete</p> | 277 individual sessions comprising <ul style="list-style-type: none"> • 64 one-off sessions • 213 sessions as part of 12 different activity series |
| Totals | 302 individual sessions comprising: <ul style="list-style-type: none"> • 69 one-off sessions • 233 sessions as part of 15 different activity series | 611 individual sessions comprising: <ul style="list-style-type: none"> • 95 one-off sessions • 516 sessions as part of 18 different activity series | 913 individual sessions comprising <ul style="list-style-type: none"> • 164 one-off sessions • 749 sessions as part of 33 different activity series |

Table 10: Summary of activities carried out as part of the project

Despite these and a few other examples, this level of information is not available for all activities. Therefore, Table 11 below presents the total number of attendances rather than the unique number of people who attended.

| | Indoors | Outdoors | Totals |
|-------------------------|---|---|---|
| Nature-based | 281 attendances by people with dementia 49 attendances by carers | 1118 attendances by people with dementia 408 attendances by carers | 1399 attendances by people with dementia 457 attendances by carers |
| Not nature-based | 1014 attendances by people with dementia 109 attendances by carers | 77 attendances by people with dementia 16 attendances by carers | 1091 attendances by people with dementia 125 attendances by carers |
| Totals | 1295 attendances by people with dementia 158 attendances by carers | 1195 attendances by people with dementia 424 attendances by carers | 2490 attendances by people with dementia 582 attendances by carers |

Table 11: number of attendances at project activities.

The Project Participants

From the information provided by some delegates through the formal reporting it was possible to identify 35 unique people with dementia who attended activities and were part of the evaluation process, and 15 unique carers.

Information was also available for 126 other people who had attended activities but not engaged with the evaluation, but it was not always specified whether these were people with dementia, carers, or others such as members of the public or volunteers.

Table 12 provides a summary of the demographic information available, broken down into sub-groups where possible.

| | | Gender | Age mean (range) | Ethnicity | Disability |
|----------------------------|--|------------------------|---|---|------------------------------|
| Part of the evaluation | People with dementia (n=35) | 51% female 49% male | 81 years and 10 months (66-92 years) (n=28) | 100% White British | 49% had a disability |
| | Carers (n=15) | 80% female 20% male | 74 years and 2 months (52-89 years) | 100% White British | 0% had a disability |
| Not part of the evaluation | People with dementia - where specified (n=6) | 83% female 17% male | 90 years and 4 months (75-104 years) | 100% White British | 17% had a disability |
| | Other/unknown (n=120) | 73% female 27% male | 82 years and 8 months (30-100 years) (n=95) | 94% White British 3% White other, 1% Black, 1% Asian, 1% mixed | 20% had a disability (n=119) |

Table 12: demographic characteristics of project participants

Additional demographic information was also provided by some delegates on an ad hoc basis and in an inconsistent format, which makes it difficult to draw any firm conclusions. Information was provided for 53 unique people with dementia and 12 carers, but it is not known how many of them took part in the evaluation.

On average, the people with dementia were aged approximately 80 years and 8 months, 64% were female (n=47) and, where given, everyone was White British. The average age for the carers was 60 years and 2 months, 83% were female and, where given, everyone was White British. It should be noted that the ages are based on vague information which required assumptions to be made, for example ‘in their 70’s’ was taken as 75. These figures are similar to those for people with dementia taking part in the evaluation, but these ‘additional’ carers were slightly younger than those in the evaluation.

Impact of activities

Based on feedback from delegates, an adapted SWEMWBS measure was used for the evaluation with people with dementia. This is a 7-item measure with each item being scored on a scale of 1-5, giving a range of possible scores of 7-35). To ensure consistency, the same scoring system was used for both versions of the measure and across both people with dementia and family carers. This means that in the results reported below, *lower scores indicate better mental wellbeing*.

Additionally, the original intention was for the measures to be completed by the same individuals at the start of a series of activities and at a couple of later time points to assess impact over time. However, many delegates who engaged with the evaluation chose to administer them with people at the beginning and end of individual sessions. The following results are therefore presented in two main ways: comparing scores before and after individual sessions; and, where possible, tracking a subset of people over time.

For people with dementia

Impact on mental wellbeing

As can be seen from Table 13, there was a significant improvement in mental wellbeing following attendance at a DAiAB activity session. This was the case when all completed evaluations were included, and also when only those with both a pre and post score for the same session were included.

| | Mean score (range) out of a possible 35 | | Significant difference at 95% |
|-----------------------------------|---|-----------------------|--|
| | Pre | Post | |
| All valid* scores | 19.22 (7-35) n=99 | 16.05 (7-27) n=108 | Significant improvement $p<0.001$, $t=1.97$ (16.5% improvement) |
| All valid matched** scores (n=94) | 19.28 (7-35) | 16.02 (7-26) | Significant improvement $p<0.001$, $t=1.99$ (16.9% improvement) |

* valid = all seven statements on the SWEMWBS were answered. ** matched = an individual had a valid score for both the pre and post measures for the same session

Table 13: Wellbeing scores pre and post activity session

To look at the impact over time, the scores for four participants who have attended multiple activity sessions have been plotted in Figure 9 below. The general trend in

all cases is that the post scores are lower than the pre ones, with fluctuations in pre scores tending to be reflected in the post scores. The exception is Participant 4 where there is less distinction between pre and post scores. Additionally, there does not appear to be a longer-term impact in that the later post scores are not necessarily lower than the initial pre score. This suggests that most of the benefit appears to occur during individual sessions rather than being maintained over time.

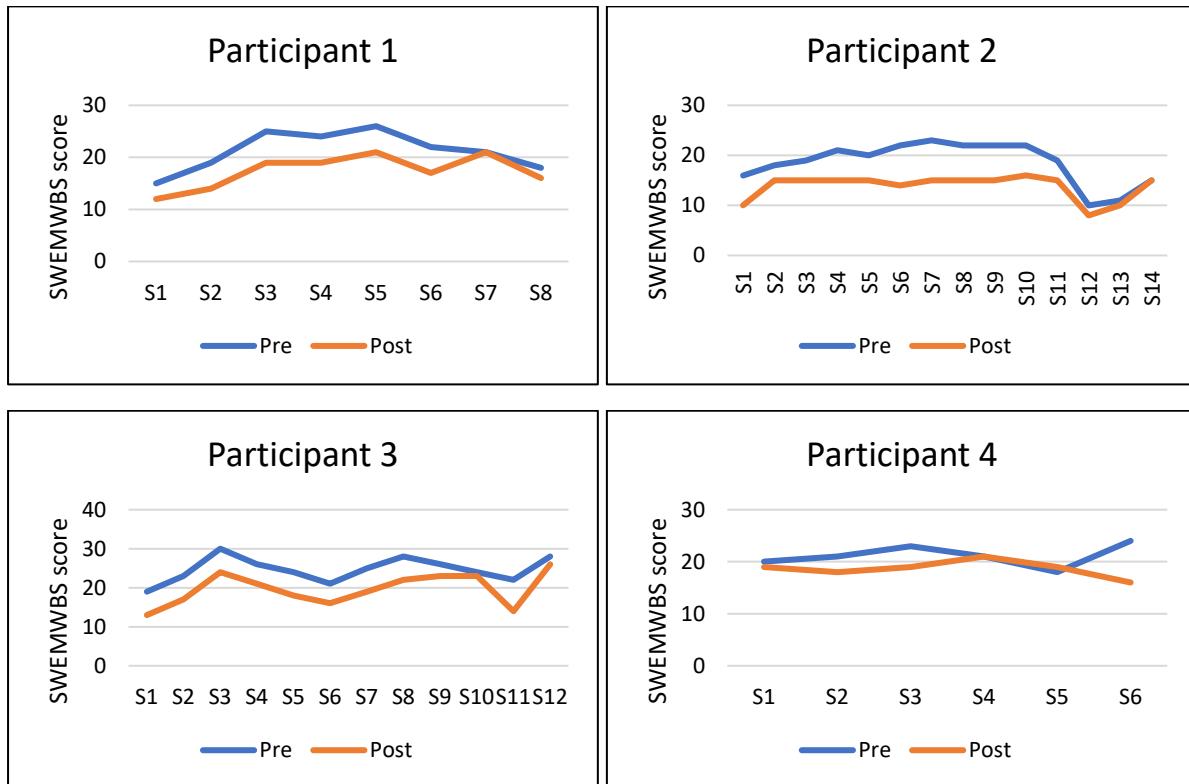


Figure 9: Pre and post wellbeing scores for 4 participants

Impact on level of activity

Participants were also asked to say how many days of the week they had done at least 30 minutes of physical activity that was enough to raise their breathing rate. Providing this information before and after an activity session was not always helpful as some activities were felt to count towards this and others were not; indeed, this is a good example of the issues that arose for the evaluation, with some delegates' deviating from the research design; this measure was intended to be collected only at the start, middle and end of a programme of activities that spanned a number of weeks or months. Table 14 below should therefore be treated with caution, but it does appear to indicate that people were more active following the DAiAB sessions. It is interesting to note that even with the sessions people were still relatively inactive with a mean of just two days a week. Sessions increased for (matched responses) participants' self-reported weekly activity levels by 0.5 days, to just over

2 days. This indicates that the DAiAB sessions form an important proportion of participants' weekly physical activity.

| | Mean no. days active (range) | | Significant difference at 95% |
|---------------------------------|------------------------------|----------------------|--|
| | Pre | Post | |
| All responses | 1.91 (0-7) (n=89) | 2.01 (0-7) (n=88) | No significant difference $p=0.76$, $t=1.97$ (5.3% improvement) |
| All matched responses (n=74) | 1.58 (0-7) | 2.12 (0-7) | Significant improvement $p<0.001$, $t=1.99$ (34.2% improvement) |

Table 14: Activity levels for participants with dementia pre and post session.

For family carers

Impact on mental wellbeing

As can be seen from Table 15, there was a significant improvement in mental wellbeing for carers following attendance at a DAiAB activity session. As for people with dementia, this was the case when all completed evaluations were included, and also when only those with both a pre and post score for the same session were included.

| | Mean score (range) | | Significant difference at 95% |
|------------------------------------|----------------------|----------------------|--|
| | Pre | Post | |
| All valid scores | 18.30 (7-30) n=54 | 15.15 (7-23) n=55 | Significant improvement $p<0.001$, $t=1.98$ (17.2% improvement) |
| All valid matched scores (n=53) | 18.28 (7-30) | 15.00 (7-21) | Significant improvement $p<0.001$, $t=2.01$ (18.0% improvement) |

Table 15: Activity levels for family carers pre and post session.

The scores for two carers were plotted over time as they had attended multiple activity sessions (see Figure 10). As with the scores for people with dementia, fluctuations in pre scores tend to be reflected in the post scores for individual

sessions. There is also a suggestion that the scores improve over time, but the sample is too small to draw any conclusions.

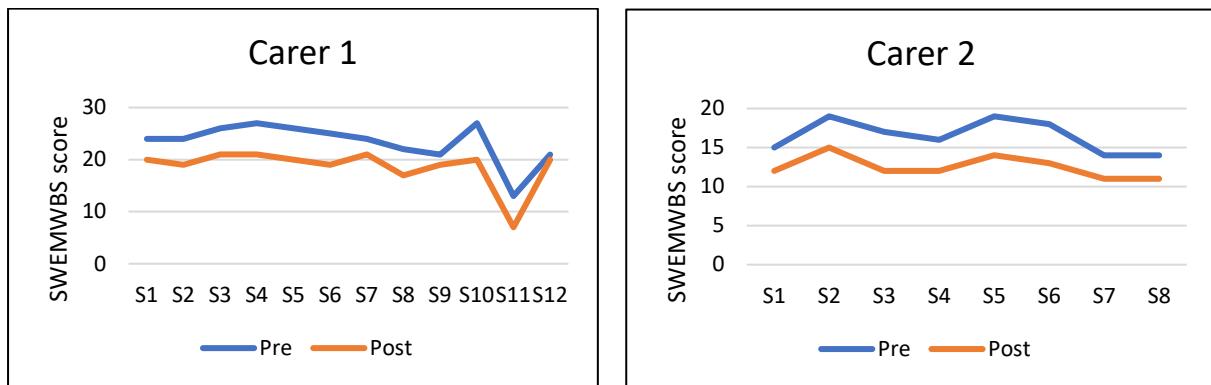


Figure 10: Wellbeing scores for 2 carers across multiple sessions

Impact on level of activity

While Table 16 shows that there was no significant change in terms of how active carers were each week, it is interesting to note that carers were more active overall than the participants with dementia, being active an average of four days a week compared to two days for people with dementia.

| | Mean no. days active (range) | | Significant difference at 95% |
|---------------------------------|------------------------------|--------------------|--|
| | Pre | Post | |
| All responses | 3.96 (0-7) n=53 | 4.21 (0-7) n=51 | No significant difference $p=0.63, t=1.98$ (6.1% improvement) |
| All matched responses (n=49) | 3.80 (0-7) | 4.21 (0-7) | No significant difference $p=0.07, t=2.01$ (11.0% improvement) |

Table 16: Pre and post project activity levels for carers.

4.3 Case Studies

Introduction

This section describes the case study work that was carried out during 2018 and 2019 as part of the evaluation, and highlights the key themes that emerged. The case studies were a key part of the evaluation and aimed to provide an in-depth exploration of the experiences and views of people with dementia and family carers who participated in activities that were held as part of the project. A second aim of the case studies was to examine how the project was implemented by each of the

providers involved, with a particular focus on identifying the challenges that they encountered along with any strategies that were used to address them.

Our case studies spanned three of the four provider organisations who took part in the project: Social Farms and Gardens (formerly Care Farming UK), Abbeyfield and MHA. Despite persistent efforts we were unable to arrange a case study with the fourth organisation, The Conservation Volunteers.

Case Study Methods

In-depth case study work was carried out by the evaluation team across a sample of participating organisations to allow a more detailed analysis of progress against the overarching project aims, including facilitators and barriers associated with DAiAB implementation and the nuanced impacts for participants. Data were collected in the following ways:

For participants in the activities (people with dementia and family carers) –

- self-reported wellbeing was measured using the Warwick-Edinburgh Mental Wellbeing Scale;
- research interviews were used to explore their experiences of taking part in DAiAB activities including the perceived impacts and any enablers or barriers to taking part;
- a small sub-sample of participants were asked to wear physical activity monitors (ActiGraph accelerometers) for a week at a time, on two occasions. The aim was to monitor the extent that Dementia Adventure activities might impact on weekly physical activity levels. It was also envisaged that this element of the evaluation would offer a valuable opportunity to pilot the use of physical activity trackers with people living with dementia.

For provider organisation staff delivering and managing the activities –

- research interviews were used to gather information about their experiences of staff and co-ordinators taking part in the DAiAB project, including facilitators and barriers.

In addition to the location-based case studies, we report here on a substantial amount of data collected through pre-arranged telephone interviews with four delegates (three from MHA and one from SF&G) and two provider leads (MHA and SF&G), an additional visit to one SF&G location to offer advice/support with the evaluation, regular telephone and email communications with DAiAB delegates throughout the project, an online forum for delegates, and researcher field notes.

Table 17 below provides a summary of the case study sites and data collected. We then go on to describe each site in detail.

Table 17: case study sites and participants.

| Locations | Date | Provider | Interviews conducted with |
|-----------------------------------|---------------------|------------|---|
| Pathways Care Farm, Lowestoft | 06/12/18 & 28/01/19 | SF&G | 1 delegate, 2 people with dementia, 1 family carer |
| Pratt House Care Home, Amersham | 24/06/19 | Abbeyfield | 1 delegate, 2 people with dementia, 1 staff member |
| This Green Moon, Rothwell | 15/11/18 | MHA | 1 x delegate |
| Scrubditch Care Farm, Cirencester | 12/02/19 & 20/08/19 | SF&G | 1 delegate, 4 people with dementia, 4 family carers |
| Live at Home, Basingstoke | 10/10/19 | MHA | 1 delegate |

Case study profiles

Pathways Care Farm, Lowestoft (Social Farms & Gardens)

Pathways Care Farm sits on a 13-acre site in north Lowestoft, Suffolk. After standing unused for some time, recent years have seen grant funding return the farm to productive use. It now works as part of the local community in bringing vulnerable people – some of whom have special needs, may be recovering from a mental health illness or are in need of some ‘time-out’ – together.

People with dementia who attended Pathways – who are termed ‘co-workers’ – are given the opportunity to learn, re-build and grow through a range of hands-on farming activities, including planting, fruit and vegetable cultivation, helping to restore farm buildings, animal husbandry and the basics of machinery maintenance. The aim is to provide support and improvement to the physical and mental health and well-being of people living with dementia and their carers.



Pratt House, Amersham (Abbeyfield)

Pratt House is a 29-bedroom care home located in Amersham, Buckinghamshire. It provides personal care to people aged 65 years and over and some of the residents have a diagnosis of dementia. The home is owned by Abbeyfield and is registered and regulated by the Care Quality Commission.

Pratt House employs two Activity Co-ordinators who provide a programme of activities – such as quizzes, gentle exercise classes and outings to local attractions – for all residents, regardless of whether they have been diagnosed with dementia or not. In line with this, there are no ‘defined’ DAiAB activities for new residents because it is all part of the ongoing care home provision. Thus, it is difficult to compare this kind of provision with that seen at the care ‘farms’ involved in the DAiAB scheme, where people with dementia have a defined ‘start’ date, and attend one or two sessions per week.



This Green Moon, Rothwell (MHA)

The MHA Live at Home Scheme in Rothwell has connected with This Green Moon, a company that runs woodland activities for children. Once a month people with dementia and their families are able to attend these activities alongside the children. The sessions are based in a small patch of woodland near a farm, requiring a short walk from a car park.

Children and adults alike can take part in a craft-based activity before gathering round an open fire, when there are also opportunities to explore the woodland more freely depending on mobility and preference. The focus is on being outdoors and socialising, especially between generations, aiming to improve mental health and well-being.



Scrubditch Care Farm, Cirencester (Social Farms & Gardens)

Scrubditch Care Farm is based in the countryside near Cirencester and began several years ago as a care farm for people with learning disabilities. Since being part of the Dementia Adventure in Box project it has been able to establish an additional day specifically to support people with dementia and their families. Originally based next to a working farm, it now has its own dedicated site with chickens, ducks, horses, pigs and sheep as well as polytunnels and outdoor space for gardening activities.

Participants are able to join in with regular activities including feeding the animals, collecting eggs, planting seeds and harvesting vegetables. These activities are not created for the participants, instead they reflect what needs to happen on a daily basis to ensure smooth running of the farm. However, the pace of farm life is adapted to the ability and mobility of the participants, and every session concludes with refreshments, preferably outdoors, where the focus is more on being sociable than productive.



Live at Home, Basingstoke (MHA)

Members of the MHA Live at Home Scheme, including those with dementia, have a wide range of regular activities available to them, including lunch clubs, music and memories sessions, outings to local places and attractions, and trips further afield. Many of the activities were already established before the Dementia Adventure in a Box project, and many have no outdoor or nature-based element to them. While DAiAB has encouraged new activities, it did not appear that any were specifically for members with dementia.

One such activity was ten-pin bowling, followed by lunch at a neighbouring pub. There was a friendly, family atmosphere where everyone had a laugh and people were included regardless of their needs or ability. A positive risk-taking approach enabled members who were less steady/stable to bowl with support rather than using it as a reason to say that they should not join in. Members with dementia were encouraged to make their own choices and do what they could for themselves, whether that was bowling, choosing their meal or helping to pay.

Case study findings

The findings from the case studies focus on two key aspects of the project: firstly the outcomes of the project in terms of its impact on the people with dementia and family carers who took part; and secondly the implementation process via which the project was managed and delivered from an organisational perspective, including some of the challenges encountered by the delegates and co-ordinators. In this section we start by describing the impact of the project for participants, and then consider the experiences of the organisations and delegates who were tasked with delivering the project. This is followed by an exploration of the key challenges and enablers associated with the project, including experiences of taking part in the evaluation.



Impacts of the project for participants

Enjoyment of outdoor spaces

Interviews with participants and delegates highlighted how much people with dementia enjoyed the activities that were organised during the project and identified a range of benefits that they associated with taking part.

We try and create an atmosphere where it's fun and there's not too much pressure on anyone, there's no need to remember anyone's name or to talk about stuff that's happened before. We just talk about what's in the moment and, you know, have a laugh, talk about what we can see. (Delegate)

I enjoy that but, I enjoy my farm, mostly...this is the highlight of my week...I'd come here 5 days. (Attendee)

...he comes back happier than when he went. (Carer of care farm participant)

For some participants, being outdoors was in itself a large part of the experience.

Oh, I love outside. Outdoors is marvellous really. (Participant)

Otherwise I think they're just—they're stuck in. The same sort of routine all day every day, and there's no, yeah no I think it does—it's nice for them to get some fresh air. Different scenery, different people. I think it does them good. (Care home activity coordinator)

Meaningful engagement in activities

There was also a feeling that the project was offering activities that were more meaningful and personal for participants than those provided in other settings.

We...realised that, there was a need to do something with people who had dementia that, would often just get pushed into a box, and left, in a care home or, or go to a day centre and play bingo which is not what a lot of people have done throughout the rest of their lives. (Delegate)

Activities are not created for the participants, they are what needs to happen at the care farm on a daily basis to make sure it runs smoothly. People enjoy being outside, feeling useful, and knowing that what they are doing has a purpose. (Delegate)

There were numerous accounts of how taking part in project activities promoted engagement for participants.

Member C came alive at Exbury gardens remembering his wife's garden and saying how proud he was of her. While on the boat trip he remembered their days boating together. His wife and he enjoyed giggling on a 'date together' while I faffed with all the boring tasks around them, leaving them to be a couple again instead of being carers. (Delegate)

We have been amazed by the way a number of our 'farm workers' (participants) have integrated and responded to the therapeutic environment we have created. Conversation has increased across the board, confidence and self-esteem appear to have risen and we get a lot of smiles. (Delegate)

Positive social environment

The social side of project activities was raised as an important benefit to those living with dementia, by participants themselves, carers and delegates. It was felt by participants with dementia that the atmosphere and support that they received whilst there was what 'made' their visits for them.

It's just a really nice atmosphere. Everybody's friendly with everybody else. (Attendee)

It's created a kind of friendship group as well as being a regular thing they come to. (Delegate)

He was sitting at home before, quite isolated or he'd just go out on his scooter and drive around he wouldn't speak to anybody. (Carer)

I mean I just love—the people are nice, you get on with everyone you—I mean you see here today, everyone is yarning and that...I mean the atmosphere is brilliant. (Attendee)

It's like I'd forgotten how to chat. (Carer)

In some locations the social benefits that arose from the project extended beyond the actual activities, whereby delegates became part of a wider support network for participants.

It was our people who went to his home, who phoned him that evening, I phoned him the following morning, we phoned his daughter, who kept phoning him to check he was alright, we phoned his wife, just to make sure that there was this continuity, and it's much more than a day-job, and that's what we believe that this is. It's holistic, and you have to be, it's not a 9 to 5. (Delegate)

Improving wellbeing

Many delegates spoke about the benefits of the project in terms of improving general wellbeing and mood of participants.

Green therapy is a winner, in most cases. We can calm people down with autism, we can help people with mental health, and we can certainly help

people with dementia 'cause we've proved it. And we've got, wonderful case notes on it...You could have one of every 10 miles, and you'd still be overrun. We've now got a waiting list for the first time ever. (Delegate)

We can see the looks on their faces. I see, the lady that's shaking and nervous and doesn't really want to be there, and you know, within no time at all she's sat down and she's enjoying the activity and she's chatting to someone next to her, and she's fine. (Delegate)

One thing I've found over the last nine years is that everyone feels happy when they're on the farm. I very rarely get a grumpy person here. Being outdoors is, you know, just so much better for everybody. (Delegate)

Some delegates suggested that there were specific benefits for people living with dementia.

Something that struck me is that there's a real emotional connection to actually being at the farm...what I'm basing that on is the feedback from the carers and the volunteers, and what they've told us about the impact that being at the farm has had and that people, erm some of the participants are remembering being at the farm and saying "when are we going again?". Which is erm, which is huge for someone with dementia because they don't— you know the memory, short-term erm recent memory is horrendous. So, actually, you know that is where I'm thinking, "actually that—that's having a massive impact, erm emotionally". Yeah for them to remember it. (Delegate)

One participant echoed this in dramatic terms.

It's been a godsend...I swear blind I don't think I've got Alzheimer's anymore. I couldn't remember all this stuff a little while ago...I think I've...cured meself (sic) like you know. I seem to remember things like that I didn't before...I did used to forget things. But I think some of it could be the fact that because I wasn't doing much, as my son says to me like "if you don't use it you lose it". (Attendee)

Maintaining identity and independence

Delegates also described how they felt it was important to support a sense of identity for participants, partly by enabling them to continue using the skills they had developed over their lives.

He was up here he was painting this wall, erm and we had someone else doing the high bits and the low bits and he was doing all the middle bits and, at the end of it he was covered in paint. And at the end of it he said "I love that". He said "I haven't done that for years, I felt like a man". (Delegate)

This was reflected in a comment made by one carer.

He, used to be a chef. And a lot of the time, they let him in the kitchen and he makes soup so all the people who are there that day they all have soup and a bread roll for lunch, that he's made and he comes home and says "oh best soup ever this week". (Carer)

In many locations there was an emphasis on enabling participants to have a greater sense of independence, which was appreciated by participants.

It's just the freedom that I have. (Attendee)

Promoting choice

Many of the positive impacts of the project appeared to be based on a flexible approach that recognised individual preferences and abilities.

I think no matter what we do at the care farm we're always flexible because people...every person is different, aren't they? No matter what sort of illness or disability they're living with they're a different...you know, they are their own individual person. So, it's about being flexible to their likes and dislikes and their needs and their abilities. (Delegate)

What we have found works best is that we treat every person as an individual and we work with them. We don't ask them to do things they are not interested in and we always work alongside. The work is a really important aspect of what we do but the breaks, coffee time and lunchtime, are highly important as well and make the day complete and rounded. (Delegate)

Several examples were given of how this approach is put into practice.

[Name] is amazing for her age, she has durable batteries. She loves physical work, particularly with the larger animals. She pushes wheelbarrows, mucks out stables, replaces the hay and straw bedding, carries buckets of water and leads the donkeys and alpacas for walks. She also enjoys a cuppa and a chat but her perfect day is to keep busy and be outside. (Delegate)

[Name] is an ex-chef. He has Frontal Lobe Syndrome and had a stroke (right hand side) about 10 years ago. He uses a motorised buggy to get around as his mobility is limited. He loves to cook and most weeks we work with him to make soup, chutney, jam, pickles etc. Every two or three weeks we get him out of the kitchen and he helps water the flowers and veg and has helped with some painting. He loves to chat and we have some great conversations around the cooker or whilst peeling potatoes. (Delegate)

In another location participants with dementia were encouraged to make their own choices and do what they can for themselves, whether that is bowling, choosing their meal or helping to pay.

Longer term impact

There was also some evidence that the project had a longer-term impact beyond attendance at the activities.

He comes back happier than when he went. So, when I get home, he's full of what he's done whereas, if he hadn't been there, he'd just sit there with nothing to say, and probably miserable. (Carer)

Experiences of and learning from the project for delegates and organisations

The interviews with delegates and project leads explored their experiences of taking part in the project, including any challenges and facilitators to implementation and delivery. These suggested high levels of enthusiasm for the project and recognition of the benefits it can bring among the delegates and coordinators.

I definitely think it's got potential it's having a huge impact which we can see quite clearly on the ground and I think if it could be rolled out it would be hugely successful. I think there's lots of organisations and groups that could pick it up and do it in some form or other, so that's all really good. (Delegate)



While some organisations involved in the project were already working with people with dementia, it made them reassess the types of activities that they run and given them the confidence to try new ideas:

It's given them a bit more inspiration for things to do (Provider lead)

It's certainly encouraged them to bring animal handlers into their sessions (Provider lead)

It has definitely started new activities (Provider lead)

For other organisations it provided the opportunity to work with a new client group:

Our staff who have volunteered on it who generally work with sort of young people who have dropped out of education and have all sorts of problems, have really loved working with the dementia group. (Provider lead)

Key challenges and enablers for the project

Recruitment of participants

Many delegates told us about the challenges of getting the project started and sustaining it for a prolonged period. These challenges centred on recruiting people living with dementia to take part in their activities.

It's unfortunate that we haven't had more people with dementia sort of coming forward and wanting to do that. I think perhaps going forward maybe we need to target them a bit more, make it more obvious that there's support for them, and actually, you know, identify individuals who we think might benefit, and sort of target them more directly, because at the moment we advertise the trips and the groups and people sign up to come. (Delegate)

When the earlier case studies were carried out some delegates had not reached the point of running any sessions, or were running sessions but were struggling to get people with dementia to attend. This was a bigger issue for those provider organisations who had less contact with people with dementia as part of their core services, such as SF&G and TCV. In contrast, MHA and Abbeyfield already had access to a potential pool of participants with dementia through their existing services (e.g. care homes, extra care housing schemes), who they were able to target relatively easily.

One strategy that was successfully adopted to address this challenge was collaboration with other organisations and groups that already worked with people living with dementia.

And there are lots of places that could do it in partnership; you know there's, memory cafes there's lots of places that we could approach and say "right, you run a dementia group, would you like to come and take part in our activity? (Delegate)



Organisation of activities

Issues relating to recruitment highlight a key difference in how activities are organised, with some being new bespoke sessions while others involve supporting people with dementia to attend activities that are already being hosted by other organisations. For example, one delegate had existing contact with a centre that runs woodland activities for children and asked if they would be willing to involve people with dementia. The main concern for the centre was making sure it was financially viable for them, so they agreed to include DAiAB participants in one session per month, with group sizes kept small to ensure a good balance (a maximum of 10 people with dementia). This approach has been successful and the sessions are enjoyed by participants with dementia.

Some delegates mentioned ‘competing activities’ by other providers as a barrier to recruiting people with dementia to the project, because they are easier and cheaper to access.

When it comes to the craft it is easier to go down to their local community centre, and do the craft. (Delegate)

Other delegates suggested that a lack of existing activities meant it was relatively easy to recruit people living with dementia, because their activities were filling a gap in the local area.

It's providing something really important locally that was missing. (Delegate)

Supporting attendance

Another challenge for some delegates was that if the person with dementia did not have a carer, they may require more support and encouragement to attend activities, which can be time consuming. However, it could be argued that these are the people who are more isolated and, therefore, particularly important to involve.

They do remind them the week before, the day before, and the morning of the activity, and then often it's still kind of half an hour before a session starts, just ringing round "are you coming? I'll see you in the park, I'll meet you there". (Delegate)

There was also a recognition that many people with dementia require the support of an informal carer to attend activities, particularly in rural areas where transport options are often limited:

It's partially getting the carers or the relatives to buy into the idea, more than getting the person themselves. (Delegate)

One delegate had responded to this by setting up a pool car system to collect people who were struggling to attend.

To some extent, it was felt to be a matter of getting information about the opportunities to the right people:

I bet there is people out there that would, really want to do—and like whose whole family and network would be, keen on them doing it but it's just, getting them to find that—it's a difficult thing to market. (Delegate)

If somebody is already going to activities with their family, they might not necessarily think that they need our services. (Delegate)

Marketing and reaching out to participants

Overall, delegates felt that they had been resourceful in terms of trying to market their services. One delegate explained how he felt that there was a “real weakness in the system” which acted as a barrier to them recruiting people living with dementia.

We were going to the GPs and we were going to social services and saying “we've got some funding, if you've got someone with an early diagnosis of dementia send them along to us, we can take them for 20 weeks”, erm, no-one was coming. We had to keep phoning up weekly and saying “have you got anyone? We haven't had any referrals”. And no-one had a referral because no-one was getting them early. (Delegate)

Changing practice

There was also a recognition that success for the project means supporting delegates to change their established practice, which can take time:

They do have some funding to take groups out to places and they do fundraising, erm but I think it's breaking their usual trips really, so they've got the places that they go to, so...Breaking habits. (Delegate)

Associated with this theme was appreciation for the high quality and value of the training provided as part of the project, particularly in terms of upskilling delegates in areas such as engagement with those living with dementia and managing risk:

Training and the, you know awareness and, you know, the confidence of people thinking "oh actually I could do this", and I think it's education and understanding it a bit more. (Delegate)

...the whole point is it's training, training, training so you know what you're doing, training to figure out how to manage risk, training to help you, make sure that the activities that you're gonna do are right, that you're not expecting an elderly person with dementia to stay out on your care farm for a 10-hour day or anything like that. (Delegate)

We already do things like risk assessments but we now—we have adapted that slightly from what we've learnt from this doing risk-benefit assessments so, we weigh up the benefits which is—which was a really valuable thing to learn. (Delegate)

Attending training sessions together with delegates from other organisations was also felt to be important as a way of sharing ideas and learning from each other:

By running the training with everybody together, it's bringing our delegates together as well as those from other partner organisations. (Delegate)

It's been really good to get together with people running either very similar projects or different projects because it's got them to think about different ways of delivering activities. (Delegate)

Some challenges were also identified in relation to the training, particularly in terms of practical issues of attendance:

I think that some of the more formal training, we've had a lot of discussions with Dementia Adventure about it and, kind of came to the conclusion that, it was a lot of effort for not a lot back, and taking people away from doing a vital role here. (Delegate)

I wish there'd been capacity for us to start the training, 'cause there were training sessions that were already on so it's not—you know I can totally understand there's no point wasting the bespoke one-to-one visit time on projects that, don't wanna be involved, but I think there would have been

capacity to, train more people in the early stages perhaps, erm then have a process for dropping out. (Delegate)

Practical concerns

It is perhaps not surprising that the weather was mentioned by several delegates as one of the main challenges to hosting activities. For some delegates this has led to indoor activities being used as an alternative:

I would say our biggest challenge at the moment is just the weather and the cold...the last session we ran and we've got another session tomorrow, has both been at the Echo Centre simply because it's just getting too cold and, you know, too difficult weather for people to come out to us. (Delegate)

Another approach by one of the care homes involved was to provide fleece-lined covers for wheelchairs and give residents the option of whether they still want to go out.

Funding

Another of the challenges that delegates mentioned frequently was accessing sufficient funding to put on new activities:

The hospital we did a session there for free, as a bit of an introduction. And the staff thought it was really good, and they wanted us to come back and do it regularly but then, they didn't have the funding for us to do that. (Delegate)

One approach that was adopted to covering the costs of organising activities was to charge for attendance. One delegate was concerned that this might stopping people from coming, but this turned out not to be the case:

We thought it was money, we thought it was funding the places and people paying for their places. But then, when we offered the places for free it didn't change...£12 was too expensive, and then we offered it for free and it was—still didn't have any uptake. (Delegate)

Funding was also raised as an issue in relation to the provider co-ordinator role. One respondent felt that the set-up period had taken up far more than the half day a week of funding that was provided within the project, while another described the challenge of meeting all of their delegates across a wide geographical area within the available funding.

The very heavy hands-on period, which was much more time than the notional half a day a week that—so I think it has evened itself out actually...it was quite hands-on, easily for the first, I don't know 6 months to a year maybe?... because it took us a while to engage with the project, because we

kept asking for, more information...it's like our money should have been frontloaded because our time and effort was...loads of time at the beginning that was way over what was, budgeted for...it's evened itself out... (Provider lead)

It can be a bit of a challenge not being in the same place as everybody all of the time. You kind of want to pop into events when people are running them. I'd like to do a bit more of that, but it's just not practical. You can't be everywhere all the time. (Provider lead)

Accessibility

A range of challenges were identified that focus on transport, facilities and accessibility. Transport can be a particular challenge in rural areas, and many delegates suggested that this had an impact on levels of attendance.

There are people I know that would quite like to come to (Name of activity) but they have issues with getting here. We just don't have enough volunteers who are willing to drive, that can run around, pick them up and get them here. It tends to be an ongoing issue, and with (Name of activity) we have to sort of say no, unfortunately we can't provide transport. (Delegate)

Some organisations had sufficient resources to collect participants from their home and take them back afterwards. Others had encouraged carers to bring the person with dementia and stay for the duration of the activity.

This is why we've made it quite open for the, the carer can stay, and join in or they can stay and have a cup of tea, or they can drop them off and leave. We try and leave it as, open to everyone. (Delegate)

Having sufficient resources and appropriate facilities to host activities was experienced as a challenge in some locations. One delegate mentioned that the amount of seating was quite limited, while another highlighted the difficulty of finding enough volunteers or staff to support participants in wheelchairs outside. At another site the combination of uneven ground and mobility issues meant that some people needed a lift from the car park to the activities, which took place in the woods.

Premises

At one of the care farms attendance was complicated by the fact that until a new building was completed the only disabled toilet was difficult to access. This made some participants conscious of the need not to drink too much while on site.

Conversation about toilets prompted a wider discussion about the issues encountered when going out in general. One carer said that they research all disabled toilets before they go somewhere new so that they are prepared.

When we go away, we went to the Isle of Wight, I took a map and found all the disabled toilets and I was writing them all down, so where we went, we knew where they were. It's difficult, I can't take him into a ladies. It's a bit worrying if we're going somewhere and there isn't any. (Carer)



Organisational approaches

There was considerable staff turnover during the life of the project, which created some challenges. One delegate told us how when the project co-ordinator from their organisation left, '*we were a bit sort of not really sure what to do*'. Other delegates who had joined the project sometime after it started said that they had not received the necessary training and would like some catch up sessions. One new co-ordinator started a considerable period of time after the previous co-ordinator had left, and this gap made it more difficult:

I felt a little bit like scrabbling round at the beginning 'cause there wasn't any handover. It was fine, but that was little bit of a challenge to begin with, following somebody else's notes. (anonymous)

Provider leads and delegates both highlighted the challenges of communication across the project. For provider leads, this largely concerned the difficulties they experienced in getting hold of some delegates, while for the delegates it was a

feeling that they weren't having sufficient contact with their co-ordinator. One co-ordinator recognised the problem and tried to adjust their hours accordingly.

If I do a Monday and I don't get back to all my emails until the following Monday, then everything takes a bit longer. [...] so I've tried to manage that by splitting it up into maybe three half days [...] because it just gives that bit more consistency. People are not waiting for replies, and I can do stuff as soon as it comes in. (Provider lead)



These challenges are perhaps not surprising given the nature of the project, whereby some provider leads had complex, multi-stranded roles, while others were working part time. Similarly, many of the delegates took on their role within DAiAB in addition to their existing busy workloads, and the very nature of outdoor activities posed challenges to communication.

Perceptions of dementia

A final range of challenges focused on perceptions and expectations in relation to the inclusion of people living with dementia in activities. Although the project was led by a high-profile organisation

that specifically supports people affected by dementia, some delegates felt that highlighting the fact that the activities were aimed at people with dementia might put off people with the condition and others without it who were also encouraged to attend. One delegate described how s/he had planned to badge some activities as 'Dementia Adventure' ones, but the feedback from some people with dementia and family members was that it felt like they were being labelled.

As a result of these concerns about stigma, some delegates were reluctant to include the word 'dementia' in any information or promotional materials that were used.

We have avoided branding the activities as Dementia Adventure so as not exclude those without memory problems or to dissuade those with memory problems from taking part. (Delegate)

Another expressed the view that participants didn't want the activities to remind them about their dementia.

I think being around animals and doing practical tasks automatically does that for you because you're focusing on what you're doing or the animal in front of you. There's no need to talk about yourself or dementia or anything

horrible that's going on. You can just focus on what's in front of you.
(Delegate)

Similarly, many delegates did not use Dementia Adventure logo or other promotional materials that had been provided because they felt it could create a barrier to participation.

Two of our regular attendees do not acknowledge that they are living with dementia, one lady in particular is quite offended by the mention of the word dementia, therefore it was agreed that the logo would be inappropriate at this time. (Delegate)

Approaches to project delivery

Case study work highlighted significant differences in how organisations approached and delivered the Dementia Adventure in a Box project. One of the key differences concerned whether new activities were arranged as part of the project, specifically for people with dementia, or whether project resources were used to recruit people with dementia to existing activities. For example, one of the care farms involved in the project already provided activities for a small group of people with learning difficulties. DAiAB gave them the opportunity to also include people with dementia in those activities, while at the same time increasing the frequency with which they occurred.

Key challenges to the evaluation

Attitudes of the delegates

Attitudes towards the evaluation among delegate respondents varied considerably. Some recognised the necessity of evaluation to provide the evidence that is needed to convince commissioners, policy makers and funders:

Whether it is possible to get it to a point where it can be socially prescribed by GPs, you know for a monetary value which would then support the work that is done on the ground, I don't know because obviously for that you need, hard evidence don't you and that hard evidence is really hard to come by.
(Delegate)

We need the information as well, it helps with us applying for funding and things like that. (Delegate)

I appreciate that the reports you require are needed for collecting the statistics and things like that. (Delegate)

And if you can get—I don't know how many case studies it would take for, whoever makes these decisions in parliament or wherever to say, "yes we'll

put the money behind it” erm, you know, do we need 100 case studies, do we need 500 case studies that all say, “this works”. Erm, that is achievable if that’s a goal—a point at which they will say “right, we’ll back it”. (Delegate)

Other delegates indicated that they didn’t think the evaluation was important; at least one delegate thought that it was an optional part of the project that delegates



didn’t necessarily have to engage with. Many respondents viewed the evaluation as too onerous, both for themselves and for the activity participants. A key challenge that was raised is the time it takes to gain consent and complete the evaluation measure, the concern being that this can take participants away from the activity itself and therefore

reduce its value. As part of our discussions it has emerged that many delegates are holding activities which they view as ‘one-offs’ rather than a series of sessions. This can make the evaluation tools seem particularly burdensome:

I think we’ve had one visit from a care home, and because it was just one visit, the evaluation forms were just way too much to fill in, when they have like four—and it was so confusing and you’re trying to explain it to their staff and...it was just, it was a bit chaotic. (Delegate)

For a start a lot of people with dementia won’t actually be able to read the form but if you’ve got someone who can read the form and can recognise that question as something, they ought to have an answer to but they don’t, that is gonna cause them distress. (Delegate)

This raises broader questions about whether the project is being delivered as originally intended; it is certainly true that the evaluation in general and the SWEMWBS in particular are likely to work better across a series of activities. However, we also know that some delegates are successfully evaluating one-off sessions on a regular basis.

Use of appropriate measures

Other criticisms of the evaluation focused on the SWEMWBS measure; some respondents felt that it was too complex for people with dementia to understand,

although this was seen as less of an issue when a family carer was also attending. Some delegates were concerned that the SWEMWBS tool could be distressing for people with dementia. This appeared to be largely due to some of the statements included in the measure about issues such as happiness, feeling worthwhile and looking to the future:

And that's what we've come up against is that our, erm volunteers have said "I am not putting that in front of my, husband, wife, person I care for it's—it will upset them, and that's not fair". (Delegate)

I know that that's a really good question to ask someone with mental health, 'cause hope is what it's all about but, if you've been diagnosed with Alzheimer's you don't think about hope for the future you think "I'm gonna die". (Delegate)

There was some recognition that the revised 'dementia-friendly' version was an improvement, but one delegate felt that this version was patronising.

Balance of data capture

Finally, there was some frustration that the evaluation was too focused on 'hard' data, and that more anecdotal evidence about the impact that the project was having was not being routinely captured.

I think the kind of evidence that would work in terms of the people involved in it is anecdotal really; it's talking to people, it's recorded conversations it's photographs, it's case studies; it's all that sort of thing, it's not going to be ticking boxes. (Delegate)

...at the end of it he said "I love that". He said "I haven't done that for years I felt like a man"....you can't ask that in a question, 'cause there's no question that would draw that out of him because he wouldn't relate to it until you're doing the task. (Delegate)

I've not heard any, bad comments about the project, about the work of the project, the only thing that I have heard reservations about is the evaluation in terms of, how complex it was for a start, you know or how complex it seemed. (Delegate)

Case Study Summary

These case study findings clearly demonstrate a range of benefits that were associated with taking part in the project. For participants with dementia, these included improved wellbeing and mood, as well as valuable opportunities for social interaction. There was a strong feeling that participants enjoyed the activities provided for a number of reasons, particularly the fact that they took place outdoors

and were relaxed and informal. The personalised nature of the activities was also valued, which meant that they were meaningful and helped maintain a sense of identity.



Some participants spoke about their past lives, and explained that they still considered themselves to be capable, skilled people. The project helped them to reconnect with their past lives and identities through activities such as farming and cooking. It was felt that undertaking 'real' tasks was fulfilling for participants, although the importance of not asking too much of those living with dementia, particularly in terms of time, was also stressed.

For the organisations involved, the benefits included access to specialist training, which led to increased confidence, satisfaction and motivation among delegates. For those organisations that didn't previously work with people affected by dementia, the project enabled them to access a whole new client group. For those organisations who did, it allowed them to expand and improve their provision, while also offering new types of activities.

A range of challenges to successful implementation of the project were identified. These included recruiting people to take part in activities, particularly for organisations who had not previously been supporting people living with dementia. Transport was another challenge, particularly where activities took place in rural areas. Several delegates and coordinators mentioned funding as a major challenge, both in terms of arranging activities and resourcing the coordinator role. Another key challenge focused on perceptions about dementia-related stigma, which influenced how the activities were publicised and branded in some situations.

However, the creative ways in which many of these challenges were addressed highlights the substantial amount of learning that occurred. For example, delegates described setting up alternative transport arrangements such as minibuses and car pools to take participants to activities. Similarly, some delegates introduced a charge for attending activities, and were pleased to discover that it didn't deter people from taking part. The learning evidenced in the case studies helped to shape and improve the project as it progressed and also provides crucial evidence to inform development of the DAiAB model going forwards.

The case study findings also suggest that the structure and culture of provider organisations can be a significant factor in the success of the project. For example, those that provide arms-length services/support to diverse locations face different challenges to those that operate within a more corporate model. Similarly, some providers made the coordinator role the sole focus of a post, while others added it to an existing role. There are likely to be benefits and drawbacks to both approaches, and the personalities and skills of individuals may be equally important, but our findings suggest that the coordinator role has operated more successfully in some organisations than in others.

Some challenges to taking part in the evaluation were also highlighted in the case study work. These focused on differing perceptions of the value of quantitative and qualitative evidence, concerns about recruiting participants to take part in the evaluation, and a feeling on the part of some delegates that they didn't have enough support in using the evaluation tools. This feedback provided valuable information for us as evaluators, and led us to adapt some aspects of the evaluation as the project progressed. It also suggests a need to engage with delegates far earlier in project development, and to be realistic about the resources that are required to provide adequate support within such a large and complex initiative.

4.4 Additional evaluation data

Monitoring physical activity levels

The years since the millennium have seen the welcome, if rather slow, emergence of wearable technology to measure physical activity behaviours of people living with dementia. A systematic review of work published between 2004 and 2014 reported 11 studies that used monitors to record physical activity for more than 24 hours in people living with dementia [1]. However, the pool of published studies remains relatively small, in part due to numerous associated challenges. For example, there can be issues around the acceptance and adoption of the monitor device, as well as logistical and emotional complications that can arise when a device needs to be removed for battery charging or to avoid water damage from baths or showers; additionally, 'goal tracking' and alarm features of many wrist-worn consumer-orientated devices can provoke anxiety [4].

Despite challenges such as these, one recently published qualitative research paper reported that the majority of people living with dementia find wearing activity monitors acceptable, with little issue wearing monitors for an entire month [5], although notably, the sample for this research included only individuals with mild



dementia. Key factors in participant perceptions of being asked to wear activity monitors were the design of the monitor, the individual's normal daily routine, the perceived benefits and external influences [5]. Another study including people with dementia and carers found that in order to encourage on-going participation, devices should be discreet, comfortable and easy to use [6]. Additionally, physical activity monitors can show the differences in patterns of activity of people living with dementia and are able to track differences in behaviour in the days when a therapeutic intervention occurred [4].

The current evaluation research aimed to explore the collection of physical data from DAiAB participants, using wearable technology, with the following aims:

- To increase understanding of the feasibility of using wearable technology to generate evidence of the contribution of programmes to improving the lives of people with dementia.
- To obtain data that would shed light on the levels of physical activity associated with DAiAB sessions, and the contribution of DAiAB sessions to participants' weekly physical activity.

The devices and instructions

To avoid as many of the raised issues as possible, the research team decided to use research-grade accelerometers (Actigraph GT3X+) to record physical activity data across 1 – 7 days. This device has been validated as a reliable tool for measuring PA in adults during their normal living conditions [7], and can be worn either around the wrist like a watch, or around the waist like a belt. They collect data silently, based upon movement as measured by axes in three planes. In order to minimise both risk of injury and the frequency with which participants might be consciously thinking about the device, they were asked to wear the device around the waist, and avoid wearing it in the bath, shower, and bed.

A noteworthy accepted limitation of wearing the monitor around the waist/hip, is that for any activities that involve standing to do work with the hands will not be captured. Participants were provided both with verbal guidance and a paper-copy set of instructions (Figure 11) about wearing the device, along with a Record Sheet (Figure 12) for participants (and/or their carers) to report any other day clubs / centres / organised activities that they had done whilst wearing the monitor. The Record Sheet was intended to enable comparison of DAiAB physical activity levels with those associated with other activities during the week.

Participants were provided with a pre-paid, addressed envelope with which to return the device after usage. In reality, in each case of devices being worn within this research, the participant returned the device to the DAiAB session leader, who then either posted the device back, or returned it to a researcher in person during a later site-visit.

Identifying Activity Levels

Collected data are processed in relation to ‘cut-points’. Cut-points are thresholds used to categorise physical activity levels as either sedentary, light, moderate or vigorous, from the number of times the devices axes have moved within a minute of time.

Different cut-points have been developed for different specific populations, as, for example, compared to children or older adults, vigorous exercise for *younger adults* will be different in terms of absolute intensity or frequency of movements per minute.

Data collected from DAiAB participants were processed using Copeland and Eslinger’s cut-points developed for older adults [8]. This defines sedentary behaviour as 0 – 50 counts per minute, light activity as 51 – 1041 counts per minute, and moderate to vigorous physical activity (MVPA) as 1,042 or more counts per minute.

Step-Counter – what to do!?

Thank-you for agreeing to wear this step-counter for a week. We do not want you to change your behaviour in any way just because you are wearing it. This is not a test, and the data will all be anonymous, so just do whatever you usually do!

The step counter will look at how much you move, but it is not able to tell what you are doing or where you are.



- Please start wearing the step-counter on the agreed day / time.
Wear it for 7 days from that point.
- Please wear the step-counter around your hips like a belt (over your belt is also fine)
- The devise itself should be at your side, just above the trouser pocket, with the arrow pointing down towards your foot.
- Avoid it getting wet. Take it off for baths, showers. If you are out in the rain, cover it with your clothing (e.g. t-shirt is pulled over it).
- Feel free to take it off at night. If you are happy to wear it at night we will get interesting data about sleep patterns, but this is not the most important thing for us, so don't worry too much.
- If you take it off at night, please remember to put it on again the next morning. Many people decide to put it somewhere that they won't be able to miss it when they wake up.
- If you end up not wearing it for some or all of the week – never mind – don't worry, there is no punishment! We appreciate that you wanted to help us with this, regardless of how it ends up going.

Please also fill-out the [Record Sheet](#) accordingly to indicate roughly what you (the 'Attendee') has done in terms of attending clubs / day centres / organised activities whilst wearing the step-counter. This should include any DAIAB activities like the activity where you were given this Step Counter.

Most importantly, at the end of the week of wearing the step-counter, please send it back to us by:

1. Placing it into the pre-paid addressed envelope we have given to you, along with the [Record Sheet](#).
2. Taking it to a post office ([please don't just put it into a post box](#))
3. Tell the Post Office staff that it needs to be "*tracked and covered for compensation up to the value of £500*"
(Although this has already been paid for, the person sending it still needs to say that these things are needed, at the time of posting)

If you have any questions about wearing the step-counter or about posting it back to us, please do just give us a call or send us an email using the contact details below.

Thanks again,
Dr Simon Evans (University of Worcester) and Dr Mike Rogerson (University of Essex)

01206 874369
mike.rogerson@essex.ac.uk

The step-counter devices are property of the University of Essex.

Figure 11. Paper-Copy Physical Activity Monitors Guidance

Record Sheet

This is about the person (possibly you!) who attends the DAIAB Activities (the activity where you were given the StepCounter)

Please complete this page and send it back to us along with the step-counter

Please record any other day clubs / centres / organised activities that you, the Attendee (person attending our Activities) have been up to whilst wearing the step-counter.

Have you (the 'Attendee') attended any clubs, day centres, or other organised activities whilst you/they have been wearing the step-counter?

If so, please make a note of what those things were, and the time and date (or day) that you/they did those things on:

| | What was it? (circle the most appropriate description) | What is the name of it? (if you are happy to tell us) | What date / day did you do this? | What time did it start? | What time did it finish? |
|---------|---|--|---|--------------------------------|---------------------------------|
| Thing 1 | Club / Day centre / Organised activity | | | | |
| Thing 2 | Club / Day centre / Organised activity | | | | |
| Thing 3 | Club / Day centre / Organised activity | | | | |
| Thing 4 | Club / Day centre / Organised activity | | | | |
| Thing 5 | Club / Day centre / Organised activity | | | | |
| Thing 6 | Club / Day centre / Organised activity | | | | |
| Thing 7 | Club / Day centre / Organised activity | | | | |

Figure 12. Record Sheet provided to participants (and their Carers) to report other Activities Throughout Wear-time

Activity monitoring results

The research team liaised with DAiAB staff and with carers where appropriate, to specifically consider the appropriateness and viability of a number of individual participants wearing a physical activity monitor. On one visit for example, it was not appropriate or suitable for any of the three participants to be involved with the physical activity monitor devices. Focussing briefly on one participant as an example, one of the research team reflected on their site visit: “if the gentleman’s wife had been there on the day it probably would have worked out, but on his own without her support he just wouldn’t have understood what it was about”. On another visit, two participants were invited to wear a device and another was not invited as they spent the majority of their time on a mobility scooter.

Both participants who were invited to wear the device, were happy to do so. Unfortunately, the data file for one of the participants unforeseeably became corrupted. Therefore, data for the remaining participant is presented as a case study.

‘Participant A’

Participant A was a man who started attending DAiAB activities at one site in July 2017, and had been attending twice weekly since then. He had a weekly routine that did not vary much from week-to-week. He was not attending any other day centres, but was taken shopping at least once a week by a friend, where he walked around the supermarket, and would occasionally go to a car boot sale locally for a look around. Participant A regularly attended two DAiAB sessions per week; one on Tuesday and one on Thursday.

Participant A wore a physical activity monitor twice; December 2018, and April 2019.

Unfortunately, he did not complete the Record Sheet on either occasion, so it was not possible to tell on which days he undertook non-DAiAB activities as described above.

December 2018

Across one week in December 2018, seven days of physical activity data were recorded. Following inspection of the data, two days were excluded from analysis: one day had missing data and the other day recorded half a day only due it being the date of returning the monitor. Therefore, trusted data collected from one DAiAB activity day (DAiAB session was attended for the hours of 11:00 – 15:00) and four non-DAiAB days were analysed.

Physical activity during DAiAB session

Surprisingly, Figure 13 indicates that Participant A was sedentary for the vast majority of their DAiAB session, with only 43 minutes of the 5 hours spent physically

active. Researcher observations indicate that sessions include time for eating and drinking, often as a group activity, and group conversation, which would account for some of the sedentary activity whilst the participant was still engaged in the social element of the group. Additionally, we suggest that the previously mentioned limitation of wearing the monitor on the hip might have contributed to this lower-than expected result.

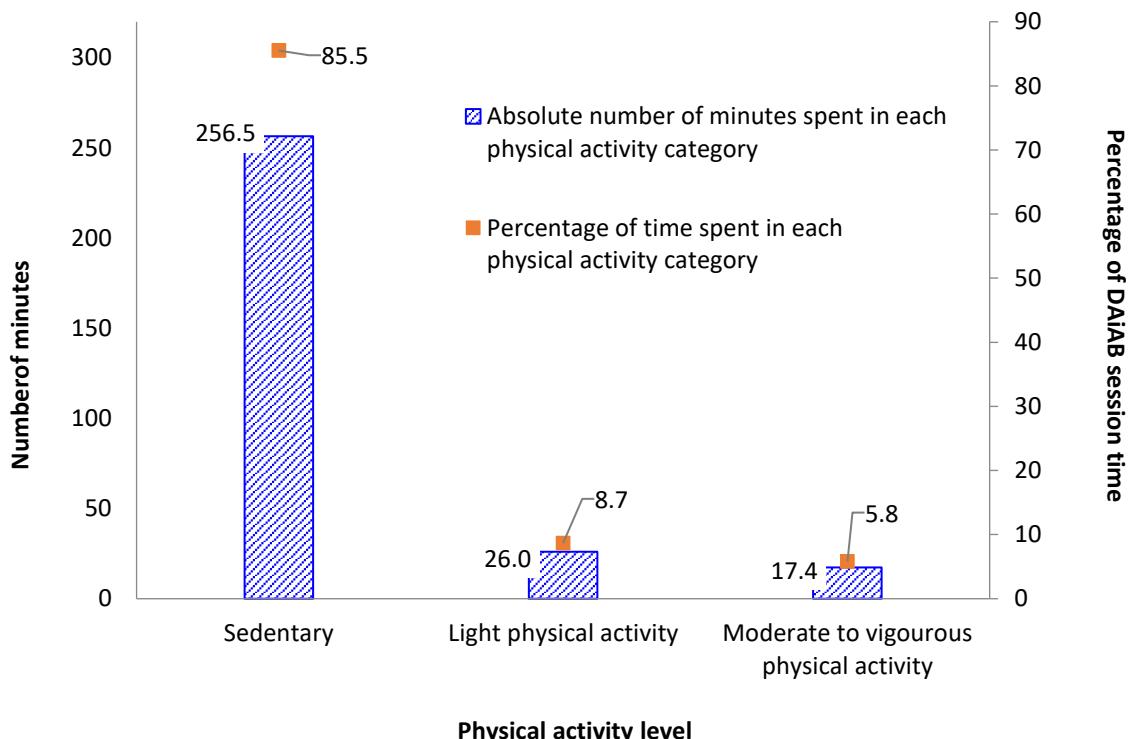
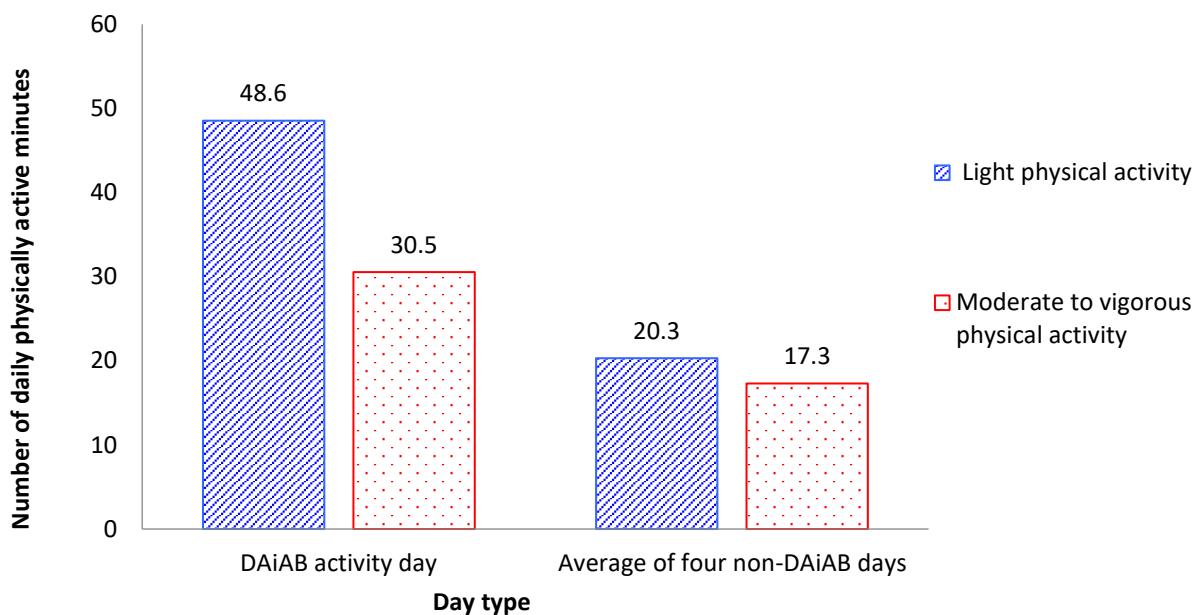


Figure 13. Participant A's absolute and relative physical activity levels within DAiAB session – December 2018

DAiAB compared to non-DAiAB days

Interestingly, participant A was over twice as physically active across their DAiAB day compared to their average non-DAiAB day (calculated as the average of all four non-DAiAB days; see Figure 14).

DAiAB sessions also made an important contribution to Participant A's total weekly physical activity. After estimating total weekly physical activity values by adding two further days at the same values as the calculated average non-DAiAB day, physical activity during the 5-hour DAiAB session contributed 29% of this Participant A's weekly 'light' physical activity and 23% of their MVPA. Based on these estimated total weekly values, Participant A completed 134 minutes of MVPA, which is only just short of the UK government's recommended 150 minutes.



All daily time not shown in the figures was categorised as 'sedentary'.

Figure 14. Participant A's physical activity levels on DAiAB activity day and on the calculated average non-DAiAB day – December 2018

April 2019

In April 2019, Participant A wore a physical activity monitor for six days, which included two attendances to DAiAB sessions. To take advantage of a fuller week of data capture, we use this to build upon the insight from the December 2018 data, by presenting day-to-day differences in Participant A's physical activity levels across the week (Figure 15).

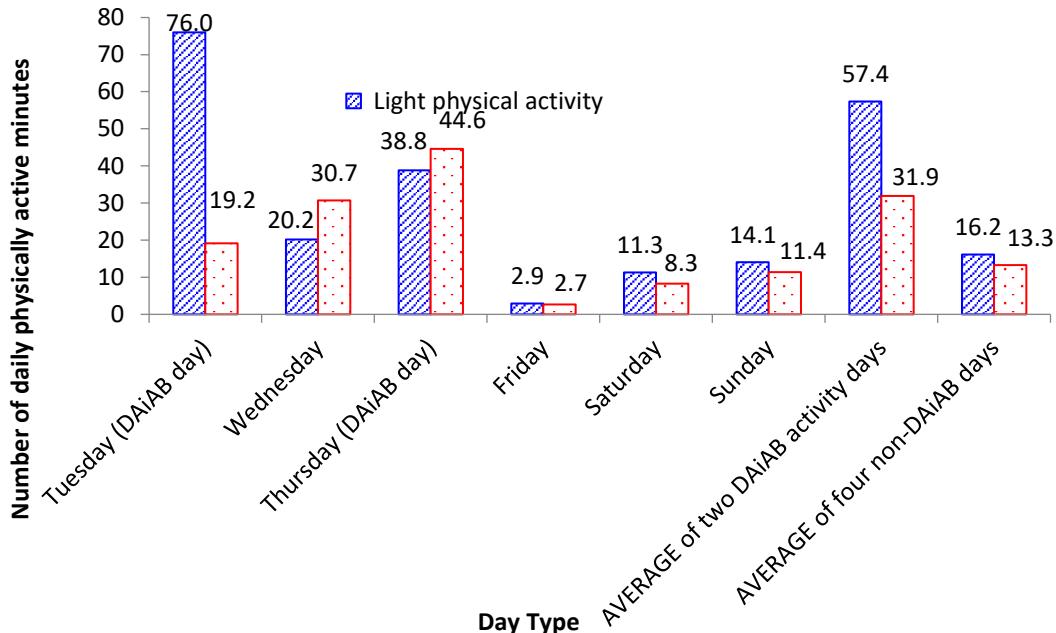
The two DAiAB days were highest in terms of Light physical activity minutes and combined light & MVPA. Highest MVPA was also achieved on a DAiAB day, and the other DAiAB day was 3rd highest in the week. The average DAiAB day represented a 238% increase in light physical activity, and a 140% increase in MVPA compared to the average non-DAiAB day.

When using the calculated average non-DAiAB day as an estimated seventh day of the week, Participant A completed 130.3 minutes of MVPA, which is close to the 150 minutes recommended by the UK government, and 38% of which was completed on DAiAB days.

Summary of findings and research reflections

In relation to the first stated aim of this section, in terms of feasibility, it proved particularly difficult to identify people living with dementia for whom it would be appropriate and viable to wear a physical activity monitor. Beyond issues around

participation consent, the extent of participants' memory loss and the support of a carer can be critical factors.



All daily time not shown in the figure was categorised as 'sedentary'.

Figure 15. Participant A's day-to -day physical activity levels – April 2019

For future attempts to use this approach with similar cohorts, the researchers feel that the Record Sheet might be more successful if amended to the format of a list of basic options that participants can tick at the end of each day. For example, including options such as: *'Today I... stayed at home; went to work; went out (e.g. to do shopping, visit a place or an event); went to a day centre'*.

In relation to the second stated aim of this section, DAiAB days consistently resulted in higher light physical activity overall physical activity time compared to non-DAiAB days, and more often than not also resulted in higher MVPA. From the presented findings we conclude that our data suggests that DAiAB sessions increase weekly physical activity levels for people living with dementia from what they would otherwise be, and make important contribution towards meeting government-recommended 150 minutes per week of MVPA. Future research should look to compare physical activity levels achieved during nature-based sessions such as DAiAB, with those at other day-care facilities.

Additional findings from online survey and regular delegate updates

Additional information about project activities and experiences was obtained from regular telephone and email contact with delegates and from a short online survey

which delegates were invited to complete as often as they wished. When combined, several themes emerged.

Defining project activities

When delegates were asked to explain their understanding of what counts as a DAiAB activity, there was an overriding understanding about “*getting people into nature*” and “*engaging with nature*”, so it is interesting that a number of activities reported did not appear to include this nature element. It was felt that the location was not overly important as both “*indoor nature based activities and outdoor outings*” were acceptable.

Additionally, the activities should be ones that “*anyone can join in*” and be “*catered towards – but not exclusively for – people living with memory problems and their carers*”.

Planning activities

Delegates reported that they tried to plan activities far in advance – for some this was quarterly while for others it was for a whole year – while retaining the flexibility to “*add in events as they come up*” on an ad-hoc basis. Planning differed slightly depending on the type of activity or the model used by delegates. For example, one delegate working on a care farm pointed out that “*some activities need to happen every day on the farm*”, so they do not have a plan as such and instead are more likely to be guided by the weather on the day and adapt accordingly. Another delegate reported that as they work with two other organisations the dates for activities had already been set by them.



Promoting activities

Newsletters appeared to be the most popular way of advertising activities, particularly for MHA delegates who have their own cohorts of Live at Home scheme members. Posters and handouts or leaflets were also used, including in public locations. Social media, in particular Facebook, also proved popular, with delegates promoting activities on their own work-related pages and also those of organisations that they work with.

Some delegates also made use of existing opportunities for promoting activities including during talks to local groups and when “*visiting and signing up all new [location] Live at Home members*”.

Branding and use of the Dementia Adventure logo

Opinions regarding the use of the Dementia Adventure logo on any promotional material varied between delegates. One delegate wears their Dementia Adventure polo shirt during activities and has the logo on their leaflets, while another uses the logo on their social media information. However, many delegates were less inclined to use the Dementia Adventure logo or actively chose to exclude it, saying:

Dementia labelling can put people off, especially if they are in denial about memory problems. (Delegate)

Two of our regular attendees do not acknowledge that they are living with dementia, one lady in particular is quite offended by the mention of the word

dementia, therefore it was agreed that the logo would be inappropriate at this time. (Delegate)

As well as being off-putting for people with dementia, it was also felt that the logo “*creates a barrier for people who want to join in but don’t have dementia*”.

Furthermore, one delegate said that they do not use the logo because they “*don’t have DA specific activities*” and instead nature and people with dementia are incorporated into their existing activities.

What delegates found worked well/not well

Delegates reported that working closely with participants on an individual basis is important during both the promotion and delivery phases of activities.

I am also responsible for assessing all new members for the [location] Live at Home Scheme. This essentially means that I meet our members living with dementia and their carers first hand so I get to explain the project to them as well as all of our other groups and activities. (Delegate)

What we have found works best is that we treat every person as an individual and we work with them. We don’t ask them to do things they are not interested in and we always work alongside. The work is a really important aspect of what we do but the breaks (coffee time and lunchtime) are highly important as well and make the day complete and rounded. (Delegate)

Some of the issues encountered by delegates included the amount of time, work and money involved in establishing new activities and attracting participants with one delegate saying that they had to withdraw from the project “*due to low uptake*”.

Small team so time spent trying to get dementia activities off the ground had an impact on existing work and activities. Difficult/time consuming to make local contacts and find service users. (Delegate)

Not core client group, so has to fit around what we already do. Not sustainable without funding or being able to charge people. Small staff team. (Delegate)

No funding to develop specific DA activities (Delegate)

Summary

The additional data captured from the delegates reflects but also enhances some of the points that emerged from the case studies. Delegates had a good understanding of the intention of DAiAB activities, but were not always able to translate that into practice as they would have liked. In some cases organisational factors were seen to

help delegates, for example in terms of providing access to potential participants, while in others they limited what delegates were able to achieve due to a lack of staff or by requiring Dementia Adventure related work to fit around their existing work. This indicates that there is no ‘one size fits all’ approach to implementing DAiAB as individual circumstances would need to be taken into account.

5. Conclusions and Recommendations

This evaluation has explored a 2-year pilot of the Dementia Adventure social licence model. Our aims as evaluators have been to assess progress against the anticipated project outcomes and to learn from successes and failures along the way. Therefore, in addition to identifying a range of impacts associated with the delivery of nature-based activities for people living with dementia and their carers, the findings



presented in this report suggest substantial learning that can be used to inform any further development of the 'Dementia Adventure in a Box' initiative. This is particularly evident from the experiences

reported by delegates and accounts of how they adapted their approaches to the project as it developed. For example, one delegate described thinking about new types of activity since being involved with the project. As a result, they took a more structured approach in the second year of the project, with a plan of monthly outings being set up, rather than just occasional ones as they did in year one. It is also interesting to note a desire for more sharing of the learning across the project:

*I wish there'd been a little bit more interaction between the different partners, 'cause some were deliverers of outdoor adventures and some were suppliers of clients; it would've been nice for a bit more of that to happen.
(Delegate)*

Project delivery

Attitudes and approaches to the project were generally very positive. There was widespread recognition of the value of connecting with nature along with high levels of engagement and enthusiasm among participants, delegates and providers. Any exceptions to this appeared to stem from a feeling that there was insufficient support in taking on what could be a complex role. For example, some delegates felt that they hadn't chosen to be part of the project and were struggling to deliver it in addition to their existing workload.

During the course of the project, 2490 activity attendances were recorded by people living with dementia and 582 by carers. The average age of people with dementia attending was 80 years and 8 months, 64% were female and, where given, everyone

was White British. The average age for the carers was 60 years and 2 months, 83% were female and, where given, everyone was White British

A wide range of activities were hosted as part of the project with over 900 being reported. Approximately 70% of these were nature-based. Over 90% of the nature-based activities occurred outdoors, while the remainder entailed bringing the outdoors inside. A small number of activities did not appear to be truly nature-based, such as ten pin bowling. There was a notable distinction between new activities for people living with dementia that were arranged as part of the project and those that were already taking place but had not necessarily included people living with dementia, but which people with dementia were encouraged to attend as part of the project.

Impacts

Our evaluation has provided strong evidence of positive impacts for people living with dementia and carers who took part in the project. Benefits identified included improved mood, greater opportunities for social interaction and physical activity, and the chance to make independent choices. There was a strong feeling that participants enjoyed the activities provided for a number of reasons, particularly the fact that they took place outdoors and were relaxed and informal. The personalised nature of the activities was also valued. Some participants spoke about their past lives, and explained that they still considered themselves to be capable, skilled people. The project helped them to reconnect with their past lives and identities through activities such as farming and cooking.

From a delegate perspective, the project provided opportunities to learn new skills and increased confidence for working with people living with dementia. The training that Dementia Adventure provided was felt by delegates to be very effective in many ways, including the ability to promote a positive approach to risk taking. All delegates reported each day had met its objectives and the content was relevant, while the trainers and materials were very highly rated. However, it was also noted that the training programme took place over a relatively long period of time, with significant time elapsing between sessions. In the context of relatively high levels of delegate turnover, the number of people completing all five days of training was low. In addition, some delegates appeared reluctant to start delivering sessions until they had been on at least a few of the training days.

Challenges

A key challenge for many delegates was recruiting people living with dementia to take part in activities that were hosted as part of the DAiAB project. This was particularly evident for providers such as SF&G who did not previously have a focus on supporting people living with dementia and was exacerbated where the location

of activity sites presented practical difficulties in terms of transport and facilities. Some delegates also described competition from activities hosted by other organisations as a challenge to recruitment.

Funding was a significant challenge to some providers, in terms of both having the resources to host appropriate activities and sufficient funding to support the provider project co-ordinator role. The former challenge was ameliorated in the second year of the project through the introduction by Dementia Adventure of a scheme for funding activities.

Many delegates described the challenges of maintaining effective communication across the main project stakeholders: Dementia Adventure, providers (delegates and co-ordinators) and the evaluation team. A relatively high level of delegate turnover was also identified as a challenge, largely in terms of the loss of valuable training and experience that it caused. Some of these challenges may be related to the differing characteristics of the four providers who took part, particularly in terms of their cultures, structures and core business. For example, SF&G provide arms-length support to a network of diverse existing organisations, most of whom had not previously delivered a specific service to people living with dementia, while MHA are a large provider of care home and community-based services to a client group including many people living with dementia.



Many of these challenges were addressed in creative ways. For example, delegates described setting up alternative transport arrangements such as minibuses and car pools to take participants to activities. Similarly, some delegates introduced a charge for attending activities, and were pleased to discover that it didn't deter people from taking part.

Several challenges to successful completion of the evaluation emerged as the project developed. To a large extent this was related to the capacity of delegates and the complexity of the evaluation. Soon after the project began, it became apparent that many delegates required more support in taking part in the evaluation than was anticipated at the project

planning stage. In addition, some delegates were reluctant to adopt the evaluation methods and tools that had been agreed between the evaluation team, Dementia Adventure and the project funders. Objections raised included that the methods were too onerous for delegates, intrusive for people living with dementia, and too quantitative in nature. Some delegates struggled with the process for gaining informed consent from participants to take part in the evaluation. Several changes

were made to the evaluation approach in response to these challenges, including the provision of more intensive and targeted training and support, which led to an increase in evaluation activity. However, the number of returned evaluation forms remained lower than anticipated. This was partly due to lower than expected levels of activity delivery, ***but it also suggest a need to engage with delegates earlier in project development, and to be realistic about the resources that are required to provide adequate support for evaluation within such a large and complex initiative.***

The coordinator role with each provider was also key to the evaluation. For some providers this worked well, with the coordinator acting as a key link between delegates and the evaluation team. For others it was more problematic, with coordinators seeming reluctant to engage and not providing regular information about activities or encouraging their delegates to engage with the evaluation. Differing approaches to implementing the coordinator role may be relevant here. For example, some providers made the coordinator role the sole focus of a post, while others added it to an existing role. There are likely to be benefits and drawbacks to both approaches, and the personalities and skills of individuals may be equally important, but our experience suggests that the coordinator role operated more successfully in some organisations than in others.

Progress against the Evaluation Framework

Table 18 below shows project delivery in relation to the evaluation framework indicators and targets. This has been revised where appropriate to take into account the withdrawal of one provider organisation at an early stage. For example, the target for number of delegates trained has been reduced from 40 to 32.

The project met or exceeded many of its indicator targets. For example, 3072 people attended activities against a target of 2034, a diverse range of activities were held and there was a significant increase in wellbeing scores for people living with dementia and carers who took part. There was also an increase in levels of physical activity associated with taking part in the project.

For some other indicators the project came close to meeting its targets. For example, 913 activities were held as part of the project against a target of 1152. Delegate Job Satisfaction was the one indicator that saw a noticeable decrease when measured before and after attending training, compared with the target of a 10-point improvement. This is a finding that merits further exploration.

| Outcome | Indicator | Target | Actual |
|--|---|--|---|
| 1. The creation and development of a strong network of partners who can work together to increase the supply of nature-based adventures | 1.1 Number of licenced partners | 4 organisations | 4 |
| | 1.2 Number of delegates trained | 32 (8 per partner) | 11 completed the full 5-day training programme. 61 attended at least one day. 64 further delegates received one-off training. |
| | 1.3 Number of locations of delegates | 32 (working in unique postcodes) | 44 |
| 2. Increase in delegates understanding of dementia and confidence in using nature based approaches in supporting people to live well with dementia | 2.1 Delegate dementia awareness/knowledge | Average 10 point improvement | 6.1 point improvement for first training day. 13.2 for delegates who completed all five days |
| | 2.1 Delegate confidence | Improvement on 0-10 scale | First day 0.4 point (5%) increase in confidence for after first training day; 2 point (28%) increase across the whole 5-day training course. |
| | 2.3 Delegate satisfaction | Average 10 point improvement on Job Satisfaction scale | For delegates who completed the 5-day course 4.4 point decrease. For the wider group 1.2 point decrease. |
| 3. Increase in local provision of 'dementia friendly' or 'dementia inclusive' outdoor activities and in the number of people with dementia taking part | 3.1 Number of outdoor activities | 12 per delegate per year ($12 \times 32 \times 3 = 1,152$) | 913 sessions in total of which: 611 outdoors (581 nature-based) 302 indoors (55 nature-based) |
| | 3.2 Number of people taking part | 24 unique individuals per year, per delegate ($24 \times 32 \times 3 = 2,304$) | 3,072 attendances (2,490 by people with dementia, 582 by carers) |
| | 3.3 Range of outdoor activities | We expect to see a diverse range of offered outdoor activities. Thematic categorisation of activities, subsequent to data collection, will identify trends | Outdoor nature-based activities: nature walks, (care) farm activities, garden centre visits, gardening activities, visits to house and gardens. Indoor nature-based activities: animal visits to care homes, making items for the garden, flower arranging/craft at café sessions. Outdoor, not nature-based: outings to town/high street, visits to fete/fair. Indoor, not nature-based: Music, singing, cinema, museum visits, café/chit chat sessions, pub lunches. |

| | | | |
|---|--------------------------------|--|--|
| 4. Maintained/improved wellbeing for people taking part in regular activities | 4.1 Self-reported wellbeing | Stability or improvement in SWEMWBS score for people with dementia; reflective indication via qualitative interviews with people with dementia | Significant improvement in SWEMWBS scores, 17% improvement. Help people to relax and be happy, feel valued by involving in activities with purpose, give them back a bit of freedom and independence. |
| | 4.2 level of physical activity | Self-reported increase in the number of days per week when undertaking physical activity | Significant average increase of 0.5 days (34%) for matched people with dementia. Average increase of 0.4 days (11%) for matched carers. |
| | 4.3 Carer coping | Stability or improvement in SWEMWBS score for carers; reflective indication via interviews | Significant improvement in SWEMWBS scores, 17-18% improvement. Socialise with other carers and get peer support, enjoy activities themselves so feel happier and more relaxed, get a bit of respite. |

Table 18: Performance against the evaluation Framework Outcomes, Indicators and Targets



It is difficult to determine whether some targets were met. For example, it was not specified whether indicator 1.2 required 32 delegates to attend all 5 training days or simply to attend some training. As the table shows, 11 delegates completed the full 5-day programme while 61 attended at least one day. Similarly, a 6.1 point

improvement in dementia awareness/knowledge (indicator 2.1) was seen for those attending the first training day, compared with 13.2 for those who completed all five days. Does this meet the target of a 10-point improvement overall?

However, the broad picture is one of a successful project that met the majority of its targets and exceeded several of them. Our evaluation certainly suggests that the project achieved the overarching project outcome of 'People living with dementia are given opportunities and support to access the natural environment, leading to improved health and wellbeing'.

Recommendations

Our evaluation findings and experiences have informed ten key recommendations concerning further development of the DAiAB model:

A. Organisational recommendations

1. Careful consideration is required when deciding which provider organisations are best suited to the DAiAB model. The evaluation found considerable differences in successful implementation between organisations who have experience of offering outdoor activities but not of including people with dementia, and those who are already working with people living with dementia but lack expertise in terms of nature-based activities.
2. Organisational structure is a key factor in how easily DAiAB can be integrated and supported within an existing service. One way to accommodate this diversity would be to provide a core model with bespoke add-ons that match the provider structure and culture.
3. A model based on a hub learning approach may work better.

B. Training Recommendations

4. Adaptations to the training model should be considered. For example, could it be delivered across a shorter period of time, based on an action learning approach?
5. Training content should be expanded to include more in-depth knowledge of dementia (including the impact of other conditions such as learning disabilities), more practical ideas for supporting people with dementia, guidance on how to work with families, and more information on how to run an activity. However, the time constraints experienced by delegates also need to be recognised.
6. An additional training session on organisational processes would give delegates the opportunity to explore the practicalities of delivering the project, including setting up activities, the key project roles, partnership working and evaluation.

C. Project Delivery Recommendations

7. More clarity is required concerning the resources (including funding) that are required to deliver the project (including the setting up of new activities) and where these resources might come from.
8. Dementia Adventure branding is a valuable resource that has been used to varying degrees by the organisations that participated in the pilot: it should be more widely adopted.

D. Project evaluation recommendations

9. Evaluation requires a high level of resourcing at all stages of the project to be effective. This includes giving evaluation sufficient time within the training programme to increase delegate awareness of what is planned and provide them with the necessary tools and skills.
10. There is promising potential to measure changes in physical activity levels, which are an important indicator of project impact, through the use of wearable accelerometers.

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7. Appendices

Appendix One: Evaluation Framework

| Outcome | Indicator: describe indicator and how you'll know you are achieving this outcome | Indicator Level: What amount of change do you expect to see | Timescale: When will this amount of change happen by |
|--|--|--|--|
| 1. The creation and development of a strong network of partners who can work together to increase the supply of nature-based adventures | (i) Number of licenced partners | 5 (partner organisations) | End of years 1,2,3 |
| | (ii) Number of delegates trained | 40 (8 per partner organisation) | End of years 1,2,3 |
| | (iii) Number of locations (of delegates) | 40 (each delegate working in a unique location/postcode) | End of years 1,2,3 |
| 2. Increase in delegates understanding of dementia and confidence in using nature based approaches in supporting people to live well with dementia | (i) Delegate dementia awareness/knowledge | An average 10-point improvement in the Dementia Knowledge Assessment Scale | End of years 1,2,3 |
| | (ii) Delegate confidence | Improvement on bespoke DA 0-10 scale | End of years 1,2,3 |
| | (iii) Delegate satisfaction | An average 10 point improvement in Generic Job Satisfaction scale | End of years 1,2,3 |
| 3. Increase in local provision of 'dementia friendly' or 'dementia inclusive' outdoor activities and in the number of people with dementia taking part | (i) Number of outdoor activities | 12 per delegate per year (starting after first six months of training) CALC: (12 activities x 40 delegates = 480) x3 years = 1200 (NB: Y1 50%) | End of years 1,2,3 |
| | (ii) Number of people taking part | Per delegate: 24 unique individuals per year and (x%) regular activity participants (regular activity participation = participation in more than x% of activity sessions offered by a given partner) CALC: (24 people x 40 delegates = 960) x 3 years = 2400 (NB: Y1 50%) | End of years 1,2,3 |
| | (iii) Range of outdoor activities | We expect to see a diverse range of offered outdoor activities. Thematic categorisation of activities, subsequent to data collection, will identify trends | End of project |

| | | | |
|---|---------------------------------|--|---------------------|
| 4. Maintained/improved wellbeing for people taking part in regular activities | (i) Self-reported wellbeing | Stability or improvement in SWEMWBS score for people with dementia; reflective indication via qualitative interviews with people with dementia | End of year 2 and 3 |
| | (ii) level of physical activity | (c) Self-reported decreases in sedentary behaviour and inactivity levels (d) Number of participants achieving 150- minutes of moderate to vigorous physical activity per week, as assessed from people with dementia and carers via interviews and surveys | End of year 2 and 3 |
| | (iii) Carer coping | Improvement in Abbreviated COPE score and reflective indication via interviews | End of year 2 and 3 |

Appendix Two: Evaluation tools – Participant and carer packs

SWEMWBS for participants – adjusted version

Below are some statements about feelings. Please tell us whether you agree or disagree with them by ticking one box on each row.

| STATEMENTS | | | | | |
|--|----------------|-------|----------------------------|----------|-------------------|
| | Agree strongly | Agree | Neither agree nor disagree | Disagree | Disagree strongly |
| I feel good about the future | 1 | 2 | 3 | 4 | 5 |
| I can be helpful to other people | 1 | 2 | 3 | 4 | 5 |
| I am feeling relaxed | 1 | 2 | 3 | 4 | 5 |
| I can deal with problems well | 1 | 2 | 3 | 4 | 5 |
| I can think clearly | 1 | 2 | 3 | 4 | 5 |
| I enjoy being with other people | 1 | 2 | 3 | 4 | 5 |
| I can make up my own mind about things | 1 | 2 | 3 | 4 | 5 |

SWEMWBS for carers

(This was also used as the original version for participants with dementia before changes were requested)

Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 weeks.

| STATEMENTS | None of the time | Rarely | Some of the time | Often | All of the time |
|---|------------------|--------|------------------|-------|-----------------|
| I've been feeling optimistic about the future | | | | | |

| | | | | | |
|--|--|--|--|--|--|
| I've been feeling useful | | | | | |
| I've been feeling relaxed | | | | | |
| I've been dealing with problems well | | | | | |
| I've been thinking clearly | | | | | |
| I've been feeling close to other people | | | | | |
| I've been able to make up my own mind about things | | | | | |

Physical activity measure

The final question asks about the physical activity you do at the moment.

In the past week, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your breathing rate?

_____ days

(This may include sport, exercise, and brisk walking or cycling for recreation or to get to and from places, but should not include housework or physical activity that may be part of your job)

Appendix Three: Evaluation tools – Dementia Adventure training sessions

The Dementia Knowledge Assessment Scale

Below are some statements about dementia. The statements are about the most common forms of dementia (those that occur most frequently). Please read each statement carefully and tick (✓) the appropriate box to indicate how true or false you believe each statement to be. Please answer each question to the best of your knowledge.

If you do not know how to respond to a statement, please show us that you **don't know** by ticking (✓) the box on the right of the page.

| | Statements about dementia | False | Probably false | Probably true | True | I don't know |
|----|---|-------|----------------|---------------|------|--------------|
| 1 | Dementia is a normal part of the ageing process. | | | | | |
| 2 | Alzheimer's disease is the most common form of dementia. | | | | | |
| 3 | People can recover from the most common forms of dementia. | | | | | |
| 4 | Dementia does not result from physical changes in the brain. | | | | | |
| 5 | Most forms of dementia reduce the length of a person's life. | | | | | |
| 6 | Planning for end of life care is generally not necessary following a diagnosis of dementia. | | | | | |
| 7 | Blood vessel disease (vascular dementia) is the most common form of dementia. | | | | | |
| 8 | Most forms of dementia do not generally shorten a person's life. | | | | | |
| 9 | Having high blood pressure increases a person's risk of developing dementia. | | | | | |
| 10 | Maintaining a healthy lifestyle does not reduce the risk of developing the most common forms of dementia. | | | | | |
| 11 | Symptoms of depression can be mistaken for symptoms of dementia. | | | | | |
| 12 | Exercise is generally beneficial for people experiencing dementia. | | | | | |

| | Statements about dementia | False | Probably false | Probably true | True | I don't know |
|----|--|-------|----------------|---------------|------|--------------|
| 13 | Early diagnosis of dementia does not generally improve quality of life for people experiencing the condition. | | | | | |
| 14 | The sudden onset of cognitive problems is characteristic of common forms of dementia. | | | | | |
| 15 | It is impossible to communicate with a person who has advanced dementia. | | | | | |
| 16 | A person experiencing advanced dementia will not generally respond to changes in their physical environment. | | | | | |
| 17 | It is important to correct a person with dementia when they are confused. | | | | | |
| 18 | People experiencing advanced dementia often communicate through body language. | | | | | |
| 19 | Uncharacteristic behaviours in a person experiencing dementia are generally a response to unmet needs. | | | | | |
| 20 | People with dementia are unlikely to experience depression. | | | | | |
| 21 | Medications are the most effective way of treating behavioural symptoms of dementia. | | | | | |
| 22 | People experiencing dementia do not generally have problems making decisions | | | | | |
| 23 | Movement is generally affected in the later stages of dementia. | | | | | |
| 24 | People with advanced dementia may have difficulty speaking. | | | | | |
| 25 | People experiencing dementia often have difficulty learning new skills. | | | | | |
| 26 | Difficulty eating and drinking generally occurs in the later stages of dementia. | | | | | |
| 27 | Daily care for a person with advanced dementia is effective when it focuses on providing comfort. | | | | | |

The Job Satisfaction Scale

For each of the following statements relating to your job, please tick (✓) the appropriate box to indicate your level of agreement.

| | | Strongly disagree | Disagree | Don't know | Agree | Strongly agree |
|----|---|-------------------|----------|------------|-------|----------------|
| 1 | I receive recognition for a job well done | | | | | |
| 2 | I feel close to the people at work | | | | | |
| 3 | I feel good about working at this company | | | | | |
| 4 | I feel secure about my job | | | | | |
| 5 | I believe management is concerned about me | | | | | |
| 6 | On the whole, I believe work is good for my physical health | | | | | |
| 7 | My wages are good | | | | | |
| 8 | All my talents and skills are used at work | | | | | |
| 9 | I get along with my supervisors | | | | | |
| 10 | I feel good about my job | | | | | |

The Dementia Adventure evaluation questions

For each of the following statements please tick (✓) the appropriate box to indicate your level of agreement.

| | | Strongly disagree | | | | | Strongly agree | | | | |
|---|--|-------------------|---|---|---|---|----------------|---|---|---|----|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1 | I know about the range of wellbeing benefits associated with access to nature and outdoor experiences | | | | | | | | | | |
| 2 | I know how to access research and other resources to increase connection to nature and plan outdoor experiences | | | | | | | | | | |
| 3 | I am confident in using risk/benefit assessment in my own role to encourage contact with nature and experience of the outdoors | | | | | | | | | | |

| | | | | | | | | | | | |
|---|---|--|--|--|--|--|--|--|--|--|--|
| 4 | I want to be a 'nature advocate' and share the benefits of outdoor nature experiences with my colleagues (and seek their involvement) | | | | | | | | | | |
| 5 | I feel able to plan nature experiences which can be personalised for each individual | | | | | | | | | | |

Training evaluation

Please provide feedback on the training you have received:

| |
|---|
| What was the most useful part of the training? |
| |
| How will the learning from this training impact those you support? |
| |
| What further development/training needs have you identified? |
| |
| Please identify 3 next steps based on the learning: |
| <ul style="list-style-type: none"> • • • |
| How could we improve our training? E.g. pace, content, method of delivery, time etc. |
| |
| Any other comments? |
| |

| Areas for rating (please tick) | Yes | No |
|--|-----|----|
| Would you recommend this training? | | |
| Did this programme meet its objectives? | | |

| | | | | |
|--|----------------------|--|-------------|--|
| Do you think the content was relevant? | | | | |
| Please rate the following (please tick) | Not very good | | Good | |
| Skills of the trainers | | | | |
| Training aids used | | | | |

| | | | | | | | | | |
|--|---|---|---|---|------------------|---|---|---|----|
| Overall, how would you rate this course? (please circle a number) | | | | | | | | | |
| Not very good | | | | | Very good | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Appendix Four: Delivery logs – Capturing activity information

Activity Coversheet

Please complete this activity coversheet at the end of the first activity session.

| | |
|--|--|
| Your date of birth | |
| Your initials | |
| Date of activity | |
| Location of activity | |
| Type of activity (e.g. walking, gardening) | |
| Total number of attendees | |
| Number of attendees experiencing dementia | |
| Number of carers | |
| Number of volunteers/other staff members | |

Activity Record

(To capture multiple sessions of the same activity, i.e. a series)

Please fill in information about each session that you run for each activity. You should record information about **everyone** taking part, not just those who are part of the project evaluation. (Please use multiple sheets if you run more than 8 sessions of an activity)

| Activity: | Session 1 | Session 2 | Session 3 | Session 4 | Session 5 | Session 6 | Session 7 | Session 8 |
|--------------------------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| Date of session | | | | | | | | |
| Start time | | | | | | | | |
| End time | | | | | | | | |
| Location | | | | | | | | |
| Number of participants with dementia | | | | | | | | |
| Number of carers | | | | | | | | |
| Number of staff | | | | | | | | |
| Number of volunteers | | | | | | | | |
| Comments | | | | | | | | |

Monthly summary sheet

(To capture information about all participants for that month)

Please record information for **all** participants and carers across all activities that they take part in. You should record information about **everyone** taking part, not just those who are part of the project evaluation. Each activity column should relate to a different activity that you run, rather than different sessions of the same activity. If a participant attends at least one session of an activity, this should be indicated by a 'Yes' in that activity column.

| Initials of individual | Gender (M/F) | Date of birth | Is the individual a person with dementia (P) or carer (C)? | Are they part of the evaluation? (Y/N) | Ethnicity (see list at end of table for codes) | Disability (Y/N) | Activity 1: Name | Comments (e.g. reason for not attending) | Activity 2: Name | Comments (e.g. reason for not attending) | Activity 3: Name | Comments (e.g. reason for not attending) |
|------------------------|--------------|---------------|--|--|--|------------------|---------------------------------|--|---------------------------------|--|---------------------------------|--|
| e.g. JB | M | 01/01/45 | P | Y | W | | Yes | | | | Yes | Missed two sessions due to illness |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
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Ethnicity codes:

W = White English/Scottish/Welsh/Northern Irish/UK

I = Irish

G = Gypsy or Irish Traveller background

OW = Any other White background

M = Mixed ethnic background

OA = Any other Asian background

OB = Any other Black/African/Caribbean background

A = Arab

O = Any other ethnic group

Monthly record of participation

(To be completed by provider leads/co-ordinators)

Every month your delegates should return to you a ‘Monthly summary of participation’ form that records which participants and carers have attended which activities. Ideally, we want to know whether any participants attend activities run by different delegates in order to avoid counting them twice.

We would therefore appreciate it if you could do the following:

- 1) Collect the monthly records from each delegate and record who has returned their form in the table below.

- 2) If you know of any participants who have activities run by different delegates, please highlight them on the returned forms or enter their details below.

| Participants/carers | Which delegates have run activities for them? |
|---------------------|---|
| | |
| | |
| | |
| | |

