

Pre-print manuscript accepted in Journal of Mental Health Training, Education and Practice (10.03.2021) 10.1108/JMHTEP-10-2020-0071

Collaborative knowledge sharing in developing and evaluating a training programme for health professionals to implement a social intervention in dementia research

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Abstract

Purpose - This study aims to explore the utility of collaborative knowledge sharing with stakeholders in developing and evaluating a training programme for health professionals to implement a social intervention in dementia research.

Design/methodology/approach - The programme consisted of two phases: 1) Development phase guided by the Buckley and Caple's training model 2) Evaluation phase drew on the Kirkpatrick's evaluation model. Survey and interview data were collected from health professionals, people with dementia and their supporters who attended the training programme, delivered, or participated in the intervention. Qualitative data were analysed using the framework analysis.

Findings – Seven health professionals participated in consultations in the development phase. In evaluation phase, twenty-six intervention facilitators were recruited. Twenty completed the post one-day training evaluations and three took part in the post intervention interviews. Eight people with dementia and their supporters from the Promoting Independence in Dementia (PRIDE) feasibility study participated in focus groups interviews. The findings show that intervention facilitators were satisfied with the training programme. They learnt new knowledge and skills through an interactive learning environment and demonstrated competencies in motivating people with dementia to engage in the intervention. As a result, this training programme was feasible to train intervention facilitators.

Practical implications – The findings could be implemented in other research training contexts where those delivering research interventions have professional skills but do not have knowledge of the theories and protocols of a research intervention.

Originality/value – This study provided insights into the value of collaborative knowledge sharing between academic researchers and multiple non-academic stakeholders that generated knowledge and maximised power through building new capacities and alliances.

Background

People with dementia need to access timely appropriate treatments, receive relevant advice, and support such as advocacy or homecare services (Lea 2015). Dementia advice services in the UK provide specialist support to those diagnosed with dementia and their families at any stage of the illness (Dementia Advisers survey 2016). Fontaine and colleagues (2011) evaluated the impact of dementia advice services reporting that dementia advisors providing support from the point of diagnosis could play a vital role in promoting independence and enhancing well-being of people with dementia. In the UK, becoming a dementia advisor requires a National Vocational Qualification (NVQ) level 3 in care or equivalent in a health and social care related subjects. The report of Fontaine and colleagues (2011) specified that dementia advisors' role is to provide a range of information, address the most common issues related to the diagnosis of dementia and signpost services to improve wellbeing for both the person and their family. Research also highlights that dementia advisors are required to be knowledgeable about a wide range of dementia-related issues, such cognitive, physical and social activities which helped to promote independence in people with dementia (Clarke *et al.*, 2011; Cornwell & Waite 2012).

Two systematic reviews have identified a range of studies adopting different methods to investigate the impact of training to improve dementia education (Fossey *et al.*, 2014; Surr *et al.*, 2017). However, training programmes specially designed to enable health professionals to become psychosocial intervention facilitators to promote independence in people with dementia is limited (Alzheimer's Society 2017; Fontaine *et al.*, 2011; Improving Quality of Care Working Group 2015). The term "psychosocial intervention facilitators" refers as practitioners from various health professional background include dementia advisors, nurses, occupational therapists, or researchers who are trained to deliver psychosocial interventions. Their role in research is to deliver psychosocial interventions to people with dementia which can be distinctly different from their everyday working. Therefore, it is important to optimise the use of a collaborative knowledge sharing approach to achieve a high-quality training programme. Collaborative knowledge sharing plays a vital role in bring people together to create new knowledge by mutual sharing ideas through communication and discussions during the process of developing and evaluating education and training programmes (Kumaraswamy & Chitali 2012). In the context of this study, knowledge sharing refers to the process of working

collaboratively between academic researchers and multiple non-academic stakeholders to generate knowledge and share of power (Kothari *et al.*, 2017).

Studies implemented a full cycle of developing education and training programmes in dementia is limited. (Surr *et al.*, 2017). Therefore, theoretical model of the training development of Buckley and Caple (2000) (e.g investigating training needs, design training, delivery training and assess the effectiveness of the training) can provide ways to open new approaches to enhance the knowledge sharing process. A further limitation that many studies only focused on one or two levels of the Kirkpatrick evaluation model (2006) Thus, utilising the four-level model of the Kirkpatrick (e.g. reactions, learning, behaviour and results) provides a useful tool to assess interrelationships of each level to achieve the efficacy of the evaluation (Surr *et al.*, 2017). Whilst many quantitative studies focus on evaluating the effectiveness of the training programme for health professionals, adding qualitative methods provides new insights into how health professionals experience transferring this learning to their practice (Sandelowski *et al.*, 1997).

This study aims to explore the utility of collaborative knowledge sharing with stakeholders in developing and evaluating a training programme for health professionals to implement the Promoting Independence in Dementia (PRIDE) social intervention in dementia research. A qualitative study aims to explore intervention facilitators, people with dementia and their supporters' experiences and perceptions of participating in the PRIDE training programme and implementing a social intervention.

Promoting independence in dementia manualised social intervention

The PRIDE study aimed to assess whether a social intervention was feasible and acceptable in people with dementia, their supporters and intervention facilitators. A total of 34 dyads of people with dementia and their supporters living in the community were recruited through four NHS Foundation Trusts across England. Participants and their supporters took part in the three-session intervention, with outcome measures collected at baseline and follow-up. To evaluate acceptability, focus groups and interviews were conducted with a subsample of participants and intervention facilitators (Csipke *et al.*, 2020).

Yates and colleagues (2019) developed the PRIDE social manualised intervention which offered a range of case studies, information, and resources to help people with dementia to explore and plan for their day-to-day activities. The activities were designed to help people stay active, remain involved in decision-making, and maintain their social connections. The use of the manual was supported by three sessions with an intervention facilitator. Intervention

facilitators were trained to deliver the intervention in three 60-90-minute sessions at participants own homes. Each session was one month apart. The intervention aimed to equip the person with dementia and their supporters to participate in activities. The intervention facilitators worked together with the person with dementia and their supporters using the PRIDE materials to identify the person's social participation needs and help them access resources already available or how to seek out for new resources in order to support them to plan activities.

Methods

There were two phases to this present study: firstly, the development of the training programme guided by the Buckley and Caple's training model (2000), then the evaluation phase drew on Kirkpatrick's evaluation model (2006) to assess the effectiveness of the training programme. We report each phase discretely. Figure 1 provides an illustration of the research activity in each phase. People with dementia and their supporters gave informed consent to participate in the qualitative study.

Phase 1 – Development of Promoting Independence in Dementia training programme

The PRIDE training programme was developed to train intervention facilitators to deliver the social intervention to people with dementia and their supporters. The theory and the practice of Buckley and Caple (2000) training model was utilised to develop the PRIDE training programme. This training model consisted of 1) investigating training needs, 2) designing training, 3) delivering training, and 4) evaluating the effectiveness of training (this process is demonstrated in phase 2).

Phase 2 - Evaluating the effectiveness of training programme

The Kirkpatrick's evaluation model (2006) comprised of: 1) reactions (e.g. measures of intervention facilitators' levels of satisfaction with the training); 2) learning (e.g. what intervention facilitators learned from the training); 3) behaviour (e.g. whether intervention facilitators utilised new knowledge and skills from the training to put in practical work) which was measured using qualitative written questionnaires, individual and focus groups interviews with intervention facilitators, people with dementia and their supporters.; and 4) results (e.g. the impact of the training on delivering the intervention to people with dementia) training programme on the PRIDE research.

Procedure and data collection

Health professionals from NHS research teams and voluntary organisations registered to participate in the training development. We aimed to recruit dementia advisors who worked in

voluntary organisations and train them to become intervention facilitators to deliver the PRIDE social intervention to people with dementia and their supporters. However, the availability of intervention facilitators from the dementia advisor workforce was limited due to their high workload and a delay in local commissioning arrangements. To overcome these obstacles, we also recruited intervention facilitators from NHS settings, such as dementia nurses and clinical dementia researchers. The training programme was delivered by members of the PRIDE research team who had been involved in the development of the PRIDE social intervention and all had previous experience of running training programs. It was a one-day training, consisting of lectures, interactive groups activities, role-play, and reflection. Managers and staff not planning to deliver the intervention were invited to attend the training to learn information to support their team members during the study.

Data collection includes three phases:

In phase 1 – A scoping review was conducted to investigate the training needs for intervention facilitators. Consultations with dementia health professionals including dementia advisors, and psychologists were conducted to identify their current role, existing working knowledge and learning needs. The consultation topic guide was developed based on Buckley and Caple (2000) training model and a scoping review Table 1a.

In phase 2 - the quantitative and the qualitative evaluation data were collected in three ways:

1) At the end of the training day, intervention facilitators completed an anonymised questionnaire. The questionnaire measured; 1. satisfaction with training, 2. whether training met objectives; 3. appropriateness of the length, 4. appropriateness of the level; 5. pace. Intervention facilitators also responded to open-ended questions about their reactions to training and reflecting on their learning on the day Table 1b.

2) Each intervention facilitator was assigned one to three interventions (cases). Each intervention consisted of 3 sessions of 60-90 minutes. After intervention facilitators completed delivering the intervention sessions (approximately three months after the training day), they were invited to a semi-structure interview. The interview guide focused on intervention facilitators gaining and using skills and knowledge from the training programme to deliver the intervention Table 1c. This data was triangulated with the reports from people with dementia and their supporters who participated in focus groups exploring their experiences and perceptions of working with the intervention facilitators during the PRIDE social Intervention Table 1d.

3) PRIDE researchers documented all the ongoing support to intervention facilitators throughout the training programme and the intervention.

Data analysis

In phase 1, Data from the expert consultation roundtable meetings were transcribed independently by two authors and discussed in the PRIDE team meetings. In phase 2, the individual and focus group interviews were recorded and transcribed professionally by (Linda, would you please provide these details, Thank you). The written feedback and interview data were analysed by two authors independently using the framework analysis (Ritchie and Spencer, 1993). The analytical process included five key stages: familiarisation and identifying a thematic framework, indexing, charting, mapping and interpretation. Quantitative data were analysed and presented as percentages of the sample. All data was checked for consensus.

Results

Phase 1 - PRIDE training programme development

The development process was iterative and covered the first 3 steps of the Buckley and Caple's training cycle (2000) which comprised 1) Investigating training needs for intervention facilitators, 2) Designing the training programme for intervention facilitators and 3) Delivering the training programme. The fourth step was to evaluate the effective of the training programme by using the Kirkpatrick's evaluation model (2006).

1. Investigating training needs for intervention facilitators

The data obtaining from the scoping review reported in the background in this study. We conducted face to face consultations with seven dementia professionals which included six dementia advisors and managers with extensive knowledge of dementia advisors, and a clinical psychologist for older people. The Consultations with the dementia professionals provided a valuable insight into current dementia advisors roles and professional training in dementia care and support in the community. For example, dementia advisors did not have experience in delivering an intervention in the context of a research study, therefore it was useful to explain the participants' pathway and their role in research. It also gave an insight into their existing knowledge and skills which helped us to focus on their strengths and translate theories and knowledge into clinical practice. Their advice and experiences were consistent with the literature indicating that training on raising awareness of dementia, and changing attitudes in care-giving practice, has been developed and evaluated within the health workforce. This information enabled us to focus on the intervention priority areas to promote independence in dementia. The knowledge sharing process provided a greater understanding

of intervention facilitators' learning needs. The findings of scoping review and consultations with dementia health professionals assisted us to establish the aims and objectives of the training programme.

2. Designing the training programme for intervention facilitators

Given the aims and objectives of the training programme were established, we planned the structure and content of the training. One of the PRIDE intervention facilitators training theories was grounded within the principles of the COM-B model (capability, opportunity and motivation and behaviour) (Michie *et al.*, 2011). Capability refers as the individual has capacity to engage in psychological and physical activities. Given opportunity to the individual accessing to resources and support that maximises their strength and influence their behaviour. Motivation defines as the individual acts energetically both physically and emotionally to achieve meaningful goals and influence decision-making. Capability, opportunity, and motivation are correlated and enacted that change someone's behaviour. Therefore, it was important for intervention facilitators to understand the COM-B model to facilitate self-management approaches within the behaviour change techniques to engage the person with dementia in an active role (Mountain 2006; Quinn *et al.*, 2016).

Intervention facilitators were also required to have a good understanding of the selection, optimisation, and compensation (SOC) model (Baltes 1997) to encourage participants to identify and engage in cognitive, physical, and social activities (Baltes & Baltes 1990). For example, selection involves identifying the skills and resources the person has and providing choices that match the person's needs. Optimisation involves making the best use of available resources to maintain the person's independence, rather than focusing primarily on losses. Compensation is the development of alternative ways or use of external aids to adapt activities that suit the person's skills and cognitive abilities (Freund 2008).

A key component of sharing knowledge was to increase confidence in translating theories to practice and replicability in delivering the PRIDE intervention. Therefore, developing a training manual for intervention facilitators to use alongside the PRIDE participant manual was vital. The intervention facilitator's training manual was developed from evidence-based literature and dementia health professionals' consultations. It contained instructions on how to implement each component of the intervention along with a suggested timetable. It also provided the background information concerning the PRIDE feasibility study and supplementary information such as the intervention facilitator's role in the PRIDE research, psychosocial theories, knowledge, skills, techniques and problem-solving through guides and "hints" (Table 3).

While investigating training needs, intervention facilitators expressed that they could not be able to take more than one day out of work; therefore, a one-day training programme was developed that incorporated pre-training preparation and post-training support that could be undertaken independently at times to suit the intervention facilitator. For pre-training preparation, they were asked to read the training manual and the PRIDE participant manual; these were sent out three weeks prior to the training.

3. Delivering the training programme

The training was delivered by the same PRIDE researchers (N=3) across the intervention facilitator's sites. The training programme comprised of three elements: an introduction to the intervention, the use of intervention facilitator's training manual and the process of delivering the intervention (Table 4). The training programme was delivered through a mixture of group teaching, demonstration, role play, and practical exercises. Using the intervention facilitator's manual assisted intervention facilitators to actively practice new skills and try a range of exercises. This consolidated intervention facilitators' learning and enabled the PRIDE research team to observe their initial understanding of the concepts presented. For post-training, the research team visited sites to ensure the training materials were in place during the active phase of the feasibility study. Intervention facilitators' monthly intervention adherence reports, emails, telephone contacts enabled the PRIDE research team to monitor the intervention progress, intervention facilitators' performance and assist with problem-solving skills.

4. The Kirkpatrick's evaluation model (2006) was used to evaluate the effectiveness of the training programme and this evaluation process is demonstrated in the phase 2.

Phase 2 - Evaluating the effectiveness of training programme

A total of five training sessions were delivered in four research sites across the UK and attended by twenty-six intervention facilitators. Intervention facilitators had variable experience of working with people with dementia in varied roles. Twenty intervention facilitators completed the post-training questionnaires. Fourteen of the intervention facilitators went on to deliver the intervention in the feasibility study. Three intervention facilitators participated in the post intervention interview. To increase credibility of data, we triangulated data from the intervention facilitator's interviews with the data from four dyads of people with dementia and their supporters who participated in the PRIDE feasibility study and had taken part in focus groups three months after the intervention. Table 2 presents intervention facilitators and participants taking part in the Kirkpatrick evaluation process. After analysing written

evaluations, post-intervention interviews, observations, and ongoing evaluations, four main themes emerged related to the Kirkpatrick evaluation including *reactions, learning, behaviour, and results*.

1) Reactions - intervention facilitators were satisfied with the training programme

Most of the intervention facilitators were satisfied with the training programme. The post-training questionnaire responses indicate that seventeen (85%) intervention facilitators reported that the training met all their objectives and expectations, and three (15%) found the training only met some of their objectives. All intervention facilitators reported the length of the training was 'about right'. Four (20%) intervention facilitators rated the overall training as 'excellent', 13 (60%) as 'very good', and four (20%) as 'good'. All of intervention facilitators rated the level and pace of the training as 'about right'.

Most intervention facilitators commented that the design of the training program was useful. It offered an interactive learning environment where intervention facilitators from difference organisations and members of the research team worked collaboratively to share knowledge.

"I just enjoy learning ...when you're with other people from other organisations... you learn something new from each other. Yes, that's the bit I liked about the training"

(Interview intervention facilitator/dementia advisor)

Intervention facilitators valued the training manual as an implementation guide offering relevant information in a clear and easy followed format.

"The intervention facilitator's training manual itself is so straightforward, and so well put together"

(Interview intervention facilitator/dementia researcher)

2) Learning- Intervention facilitator learnt new knowledge and skills

Most intervention facilitators reported that the training course provided a collaborative knowledge sharing environment which increased interpersonal communication to learn new knowledge and skills among intervention facilitators. Participating in role plays based on case stories or vignette in pairs and small groups enabled them to share their experience, discuss and learn how to deliver the intervention in pragmatic ways that would positively impact on people with dementia.

"Discussing scenarios and possible outcomes may be ways of empowering people with dementia... I liked the informal delivery - I felt confident to ask questions and discuss issues raised"

(written feedback intervention facilitator/dementia advisor)

Intervention facilitators found the training was very comprehensive. It covered all aspects of the intervention which required to deliver the intervention. Understanding the differences between each of the sessions of the intervention and learning new information and skills to deliver the sessions improved intervention facilitators' competencies in developing strategies to solve problems when things may not go according to plan.

"Good to know practicalities of running the social intervention and problem-solving scenarios"

(Written feedback intervention facilitator/dementia researcher)

However, one intervention facilitator did not enjoy the role play as "it was awkward doing things like role play" and thought it was not an essential component in this training, but some video clips of a participant taking part in a session would have been useful. Intervention facilitators found the training created a safe and supportive environment to learn new knowledge and skills with confidence.

"I felt that the training was comprehensive, it explained everything, any questions were answered, I really enjoyed the training"

(Interview intervention facilitator/dementia advisor)

It was suggested that the training would be useful to spend more time on an overview of the study, particularly, the participants' pathway throughout the research.

"Overview of the study – participant pathway at start would help to set the scene and understand the full study and how intervention facilitators work relates"

(Written feedback intervention facilitator/dementia research manager)

Having more examples for practical work would increase intervention facilitators' confidence in delivering the sessions.

"Maybe build in time to work through a few more examples - or some examples of completed sections of the manual, just to see how it's filled out and how much detail"

(written feedback intervention facilitator/dementia researcher)

3) behaviour-Motivating people with dementia to engage in the intervention

Applying the theories of COM-B (Michie *et al.*, 2011) and SOC (Baltes 1997) in practice enhanced intervention facilitators' capability to motivate participants to engage in the intervention. A supporter whose husband was newly diagnosed with dementia emphasised the importance of the intervention facilitator visiting which made a huge difference in increasing the level of the participant confidence.

“...very good that it gave you an outline because when you come away from the hospital, or you have been given a diagnosis, you don’t really know what to expect and when someone came along and explained things it was quite a help... We won’t have known where to start without the intervention facilitators coming. They came in and got him interested in things straight away, so his confidence didn’t go”

(interview supporter)

Three participants were given a range of choices to start new activities and maintain mentally and socially activities (e.g. arts, games, and sports activities). People with dementia spoke about the relationship with the intervention facilitators and perceived it was a key part of their engagement in the intervention.

“I just thought when somebody came along and spoke to you about it (the intervention) and explained things, I thought it was very helpful and gave you a bit more confidence with the situation you were in”.

(interview person with dementia)

However, some intervention facilitators experienced challenges when delivered the intervention to people with dementia whose were already actively engaging in activities and displaying high levels of autonomy and motivation.

“Quite challenging. I had one participant who was very independent and very able, and so trying to find things for her to do, was really difficult.”

(Interview intervention facilitator/dementia researcher)

Despite all the challenges in delivering the intervention to meet the different needs of participants, intervention facilitators demonstrated their ability of providing a good practice.

“ensured that people were constantly putting things in place and made sure that they lived independent active lives and stay in control”

(Interview intervention facilitator/dementia researcher)

Intervention facilitators found working collaboratively with researchers in an ongoing supportive environment which increased their competence to deliver the intervention.

“if I needed to get hold of the team, there was always someone there that I could get hold of”.

(Interview intervention/dementia advisor)

4) Results- the training programme is feasible to train intervention

Our findings indicate that this training programme was feasible to train intervention facilitators to deliver the PRIDE social intervention. We ran a fidelity study within the feasibility study of the PRIDE intervention indicating there was fidelity to the intervention (Walton *et al.*, 2019). People with dementia completing the fidelity checklists indicated better engagement self-management ability at baseline and remain the same level at the follow up (Csipke *et al.*, 2020).

Discussion

This study reports on the full cycle of developing and evaluating a training programme for health professionals to implement a social intervention for people with dementia and their supporters in the PRIDE research study. Our consultation findings indicate the importance of engaging stakeholders in identifying intervention facilitators' training needs. This step leads to a comprehensive training programme and a short one-day structure training programme that was acceptable for all stakeholders and feasible for a variety of dementia workers, whose diverse work roles meant further time out of the workplace was not viable. Drawing on education theories provided a systematic approach to reflect on training in a logical way with review at each stage. The collaborative knowledge sharing approach between intervention facilitators and PRIDE researchers, which included training preparation, active participation in the training and regular contact post training with the research training team created a space of interactive learning environment and increased intervention facilitators' knowledge, skills, competencies and confidence (Buckley & Caple, 2000; Elen *et al.*, 2007). This consultation roundtable meetings provided the opportunity for health professionals and PRIDE researchers to open to new ideas and creativities. Working in knowledge sharing environments may improve collaboration among health professional and academic researchers (Sabeeh, Mustapha and Mohamad 2018).

The robustness of the evaluation of training was strengthened by using the Kirkpatrick's evaluation model (2006), which enhanced the effectiveness of the training in achieving its aims. The Kirkpatrick's evaluation model (2006) has four levels and we collected different types of data at different stages to evaluate the efficacy of our training programme. Level 1 evaluating the reaction of the learner, here we captured data immediately after the one-day training course using questionnaires with open text boxes. The use of post-training questionnaires enabled us to identify number of practical implement benefits and problems. To explore and address this, we included questions about the training when we undertook interviews using the Kirkpatrick's evaluation model (2006).

The structure of the training day and the supporting training manual enabled intervention facilitators to increase their understanding of research roles, intervention theories and professional development skills (Peters et al., 2018). This suggests that the methods we used may be transferable to other health and social care contexts. The evaluation of the training suggests that a rigorously and systematically developed one-day training programme including pre-training materials and post-training support enabled intervention facilitators to internalise complex theories of intervention research such as transferring COM-B (Michie *et al.*, 2011) and SOC models (Baltes 1997) into clinical practice. Intervention facilitators found that it was beneficial to learn together with a mixed group of practitioners and share their experiences which promoted learning new skills and increasing capacities (van de Pol *et al.*, 2015).

At level 2, our results indicate that intervention facilitators had assimilated new knowledge and were applying it in their practice. The training programme facilitated intervention facilitators to actively practice skills and enabled PRIDE researchers to observe intervention facilitators initial grasp of the concepts presented. Providing continued support to intervention facilitators might assist them to clarify any areas of uncertainty they might have had and develop strategies to solve the problems that boosted their confidence. This process gave PRIDE researchers an opportunity to go back to each initial step and assess the outcomes of the training cycle and increased their confidence. Intervention facilitators received ongoing support from the PRIDE research team such as receiving further information or developing problem solving strategies. Continued support can help intervention facilitators increase their confidence and competence to translate their new knowledge and skills into clinical practice (Fossey *et al.*, 2020). Providing the opportunity for intervention facilitators to learn new information is key for successful knowledge sharing activities (Sabeeh, Mustapha and Mohamad 2018).

The level three evaluation focuses on behaviour change in intervention facilitators. Our findings support that knowledge sharing collaboratively was a core component to enable intervention facilitators to practise good communication skills and provided a range of choices and encouragements to motivate people with dementia and their supporter to engage in the social intervention (Pals et al. 2020). Given an interactive face to face and group-based learning environment which enabled intervention facilitator to engage in active learning could optimise the potential of behaviour change (Surr *et al.*, 2020) and increased positive perceptions and attitudes towards collaborative knowledge sharing (Marouf 2015).

The final level of evaluation explores the effect of the training on the research. The evaluation process reflects the ability of intervention facilitators in transferring theories and knowledge sharing to gain new skills to implement the intervention. As results, this training programme is feasible to train intervention facilitators to deliver the PRIDE social intervention for people with dementia and their supporters. It may be important for researchers to plan training programmes within randomised controlled trial to consider ways in which they might evaluate effectiveness of training during the trial rather than waiting for an end point.

The strengths and limitations

A rigorous methodology and the qualitative data offer insights in the process of knowledge-sharing. This process provides a greater understanding on the value of different forms of collaborative approach in generating knowledge and sharing of power between academic researchers and non-academic stakeholders. The wider implications of sharing experiential and academic knowledge in development and evaluation of the training programme could be implemented in research training contexts where those delivering research interventions have professional skills but do not have knowledge of the theories and protocols of a research intervention. Involving health professionals such as dementia nurses and clinical researchers in the study enhanced the knowledge sharing through diversity of learning and sharing skills. This study has limitations. We acknowledge the small sample size. There was a lack of pre and post comparative evaluations of intervention facilitators' competence and confidence in delivering the intervention. A convenience sample for the interviews may have led to the underrepresentation of the intervention facilitators attending the training and the people with dementia and their supporters. Therefore, it is important to take into any potential bias in the findings. Intervention facilitators identified some areas for improvement in the training package, for example that it would be helpful to incorporate video of sessions in action and be aware of people's learning needs such as role plays to make sure they were comfortable with certain exercises (Buckley & Caple 2000). In our study intervention facilitators reported difficulties with delivering the intervention to those who were already independent, yet this was a factor which did not come in in our consultative phase, reinforcing differences between research and clinical practice.

Conclusions

The training programme brings new knowledge and skills empowering intervention facilitators to motivate people with dementia to engage in the PRIDE social intervention. The full cycle of development and evaluation of this training programme provides a systematic approach to optimise the use of knowledge sharing between dementia health professionals and research academics. This reflects the benefits of working collaboratively between academic

researchers and multiple non-academic stakeholders in ways that generated knowledge and maximised power through building new capacities and alliances. Providing the intervention facilitator's manual before the training reduced the contact time required of learners and made the training more accessible to health professionals in employment. Importantly, the training programme was delivered by the research team which enabled the early development of positive working relationships that were then consolidated by regular contacts with intervention facilitators during the feasibility study. This training programme is feasible and acceptable to train intervention facilitators in the PRIDE main randomised controlled trial. Drawing on empirical theories from education is important and provides the tools for effective evaluation which will enhance training in future global intervention studies.

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Figure 1
The process of development and evaluation of the PRIDE training programme

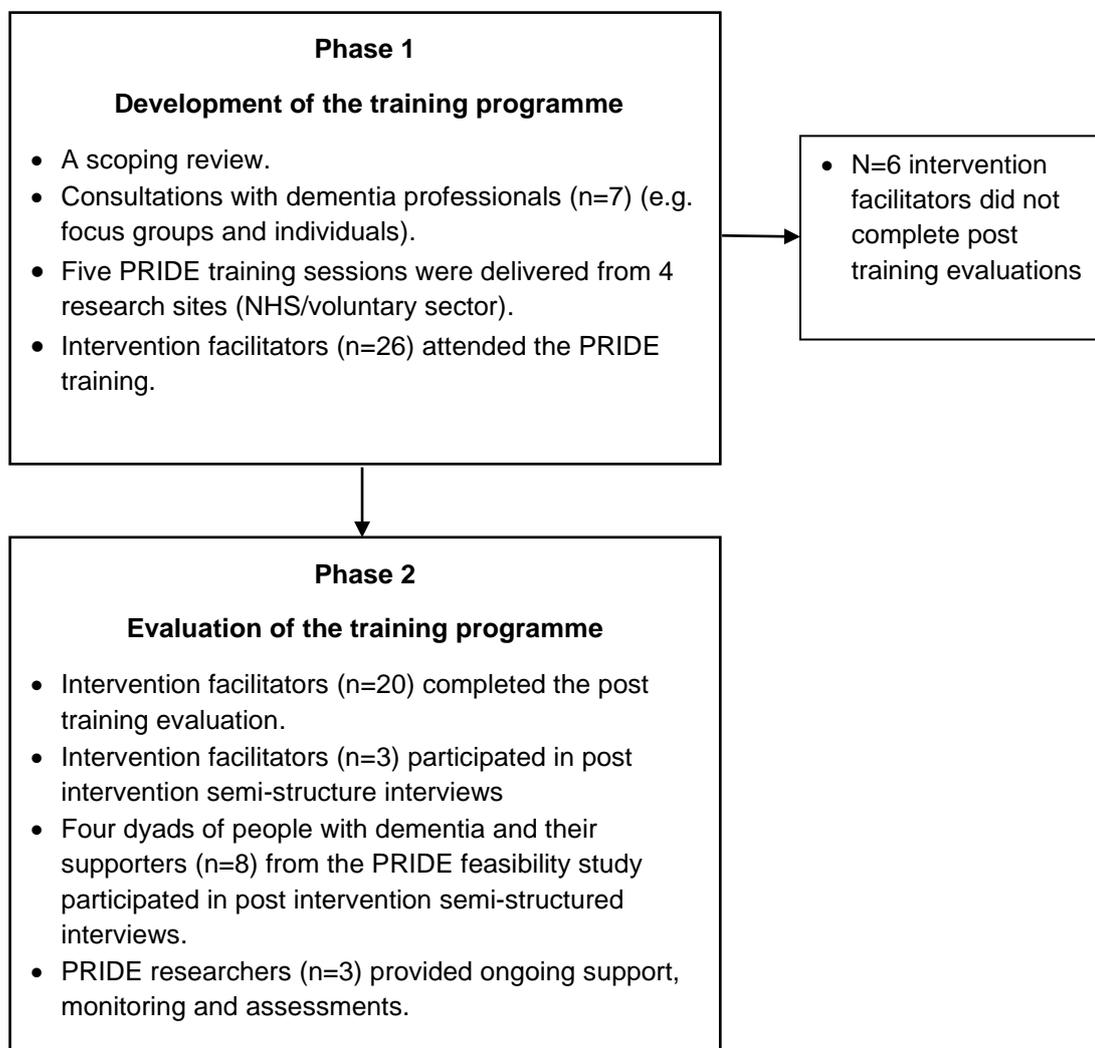


Table 1a, Topic guide for consultations

| |
|--|
| <ol style="list-style-type: none">1. Professional background<ul style="list-style-type: none">• What is your current role in your organisation?• What qualification is required to become a dementia advisor?2. Your experiences and skills in psychosocial research<ul style="list-style-type: none">• Have you had any experiences in participating in dementia research and delivering psychosocial interventions in dementia? Or attended any training to deliver psychosocial interventions?3. Your existing experiences and skills<ul style="list-style-type: none">• What experiences and skills you will bring to the research project?• If you have not had any experiences and skills in delivering psychosocial interventions, what would like to learn, particularly to deliver the PRIDE social intervention?4. PRIDE intervention facilitators training design.<ul style="list-style-type: none">• What training methods will be useful and meet the learner training needs?• What information will the training and the training manual include?• How to assess learner support needs? |
|--|

Table 1b Topic guides for post training evaluation for intervention facilitators

| |
|---|
| <ol style="list-style-type: none">1. How would you rate the training overall?2. Was the length of the training suitable?3. Did the training meet your objectives? Please add comments.4. Was the level of the training suitable?5. What was most useful today?6. To what extent did the training help you to increase your understanding of the PRIDE social intervention?7. Which aspects of the training could be improved? |
|---|

Table 1c Topic guides for post social intervention semi-structured interviews with intervention facilitators

| |
|--|
| <ol style="list-style-type: none">1. To what degree were the skills and knowledge taught in training useful for delivering the social intervention? e.g. practical skills, theoretical knowledge?2. Did you use the intervention facilitators training manual alongside the PRIDE manual? If so, did how did this work? If not, why not?3. Which parts of the intervention facilitators training manual are most useful when delivering social intervention session?4. Which parts of the intervention facilitators training manual might need to change? If so, what changes would you make? e.g. omitting content (and what?), adding content (and what?)5. Have you experienced any barriers to applying what you learned in training to the social intervention? |
|--|

Table 1d, Topic guides for post social intervention interview with people with dementia and their supporters

| |
|---|
| <ol style="list-style-type: none">1. How was your experience of working with intervention facilitators? |
|---|

-
2. Did you make any changes to your activities/lifestyle/actions related to taking part in this program? If so, what changes did you make? Why? If not, why not?
 3. What are your perceptions about intervention facilitators delivering the social intervention?
 4. What is your experience taking part in discussion of planned activity?
-

Table 2, Intervention facilitators and participants took part in the Kirkpatrick evaluation process.

| | |
|--|--|
| Intervention facilitators attended one-day the training (n=26) | <ul style="list-style-type: none"> • Dementia advisors (n=11) (43%) • Dementia clinical researchers (n=7) (27%) • Dementia nurses (n=4) (15%) • Allied health professionals (e.g. managers) (n=4) (15%) |
| Intervention facilitators completed the post training evaluation (n=20) | <ul style="list-style-type: none"> • Dementia advisors (n=7) (35%) • Dementia clinical researchers (n=5) (25%) • Dementia nurses (n=4) (20%) • Allied health professionals (e.g. managers) (n=4) (20%) |
| Intervention facilitators went on to deliver the intervention (n=14) | <p>Intervention facilitators did not deliver the intervention (n=12) due to</p> <ul style="list-style-type: none"> • high workload (n=6), • left the organisation (n=2) • had no participants (n=4) |
| Intervention facilitators participated in the post intervention interviews (n=3) | <p>Intervention facilitators were approached for the interviews (n=6)</p> <ul style="list-style-type: none"> • Declined due to work commitment (n=1) • Left the organisation (n=1) • Did not deliver the intervention (n=1) |
| People with dementia and their supporter participated in the post intervention interviews (n=8) | <p>People with dementia</p> <ul style="list-style-type: none"> • Mean age • Gender <p>Supporters</p> <ul style="list-style-type: none"> • Mean age • Gender |

Table 3 - The PRIDE training manual

| Topic | Training content |
|--|--|
| Dementia Services | <ul style="list-style-type: none"> • Overview of dementia advice services • Role of intervention facilitators |
| The PRIDE social intervention feasibility study | <ul style="list-style-type: none"> • Aims and objectives • PRIDE intervention facilitator’s role • The PRIDE research and social intervention procedure • Support to intervention facilitators |
| Theory of social participation and communication competencies | <ul style="list-style-type: none"> • Capability, opportunity and motivation-behaviour model • Self-management approach • Social network and activities • Selection, Optimization, Compensation model • Guides and “hints” to interpersonal communicational skills and techniques to engage with the person • Problem-solving strategies |
| Intervention facilitator’s training | <ul style="list-style-type: none"> • What does the PRIDE manual contain? • Resources & information • Case stories • Three core topics and seven choices of topics • When is the manual used? • How does the menu system work? |
| Social intervention: session 1 | <ul style="list-style-type: none"> • PRIDE profile; PRIDE guide and complete PRIDE profile • Key information; finding a balance, people and connections and keeping going • Choice of topics; choose 3 topics from keeping mental health, physical health, socially active, making decisions, getting your message across, what does it mean to be told you have dementia? and keeping healthy. • Plan: plan an action or activity using the chosen topic resources. This process helps the person to achieve their goals • Do: explain how record progress between sessions • Review and support: give positive feedback and opportunity to ask questions, provide contact details and methods of future support • Next session; set a time and date |

Social intervention: sessions 2 & 3 Review the progress of the previous plan and make a new “plan” and “do”. In session 3, the person is given support to continue after the intervention is completed

Table 4 - An overview of one-day PRIDE training programme

| Contents | PRIDE social intervention feasibility study |
|--|---|
| An introduction to the intervention training | <ul style="list-style-type: none"> • Aims and objectives • PRIDE intervention facilitator’s role • The PRIDE research and social intervention procedure • Support to intervention facilitators |
| The used of intervention facilitator’s training manual (see table 1 for further information) | <ul style="list-style-type: none"> • Overview of dementia • Understanding the benefits of staying active • Theory of social participation and communication competencies |
| The process of delivering the intervention | <ul style="list-style-type: none"> • Introduction to the PRIDE participant manual • Overview of session one • Initial PRIDE activities • Choice of topics • Key information • “Plan”, “Do” and “Review” process • Thinking about the next session (a month later) • Providing support to the person and their supporter • Overview of sessions two and three • Thinking about how PRIDE intervention can help the person with dementia and their supporter in the future. |
