Reducing Stress and Distress Programme:

Evaluation report

Evaluation of 12-week sprint model for cohorts 1-4

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Contents

Executive summary

This report summarises the impact and learning from the Reducing Stress and Distress Improvement Programme for the period January 2025-March 2026, delivered by Healthcare Improvement Scotland, Care Inspectorate and NHS Education for Scotland.

Key information

Meaningful improvements for people with dementia

Teams reported impact on quality of life for people living with dementia. This included improved sleep, social engagement, and confidence.

Positive safety outcomes

Teams reported reduction in pharmacological interventions, accompanied by reduced periods of stress and distress and calmer, more engaging environments. Several teams saw fewer falls.

Strengthened staff confidence and collaboration

Staff felt more equipped and motivated, describing themselves as ‘more strong, more equipped to support people with stress and distress’. Multidisciplinary teamwork improved across settings.

Clear priorities identified through self-evaluation

The Reducing Stress and Distress Self-evaluation Tool successfully pinpointed key improvement priorities. Teams performed best in early identification and person-centred care planning, with the greatest opportunities for improvement in meaningful activity and continuous intervention.

12-week sprint model delivered strong early progress

Attendance at learning sessions was high, though follow-up engagement was lower, especially for care homes – 80% of teams reached the stage of testing change ideas.

Collaboration across Healthcare Improvement Scotland, Care Inspectorate and NHS Education for Scotland was a major strength

Joint delivery brought complementary expertise and consistent support, despite initial challenges with IT, communication and differing organisational systems and ways of working.

Programme learning is shaping future delivery

Programme delivery has been redesigned for 2026 based on learning from participants: 12-month duration, increased coaching support and improved content. This will enable participants to fully test and evidence the impact of changes and support sustainability and spread of improvement.

Introduction

The Reducing Stress and Distress Improvement Programme works with care home and hospital teams across Scotland to improve person-centred approaches to support stress and distress for people living with dementia. Building on a national commitment to improve outcomes for people living with dementia, the programme aligns to the Dementia Strategy for Scotland: Everyone's Story and is grounded in a rights-based approach. The programme also supports the delivery of key standards and guidelines, such as the Scottish Intercollegiate Guidelines Network (SIGN) Guideline 168: Assessment, diagnosis, care and support for people with dementia and their carers and Health and Social Care Standards: my support, my life.

The programme brings together multidisciplinary teams to develop, test, and embed practical changes that enhance wellbeing, reduce avoidable harm, and improve staff confidence in delivering compassionate, trauma-informed care. This programme was developed jointly by Healthcare Improvement Scotland, Care Inspectorate, and NHS Education for Scotland (now formally known as Public Services Delivery Scotland).

This evaluation report looks at the delivery of the 12-week sprint model during 2025, involving 55 participating teams from a wide range of care home and hospital settings, and shares learning from the delivery organisations and participating teams. It draws on self-evaluation findings, examples of tested improvements, early evidence of impact, and feedback from participants and delivery partners. The report also reflects on the programmes collaborative design and highlights how this partnership has shaped both the content and delivery of support.

Background

The Reducing Stress and Distress Improvement Programme was designed and delivered as a collaboration between Healthcare Improvement Scotland, Care Inspectorate and NHS Education for Scotland. In 2025, the programme supported 55 hospital and care home teams to develop and implement improvement to better support people living with dementia who experience stress and distress.

The programme aimed to improve outcomes for people living with dementia through the implementation of person-centred approaches to prevent and support stress and distress. In addition, the programme aimed to:

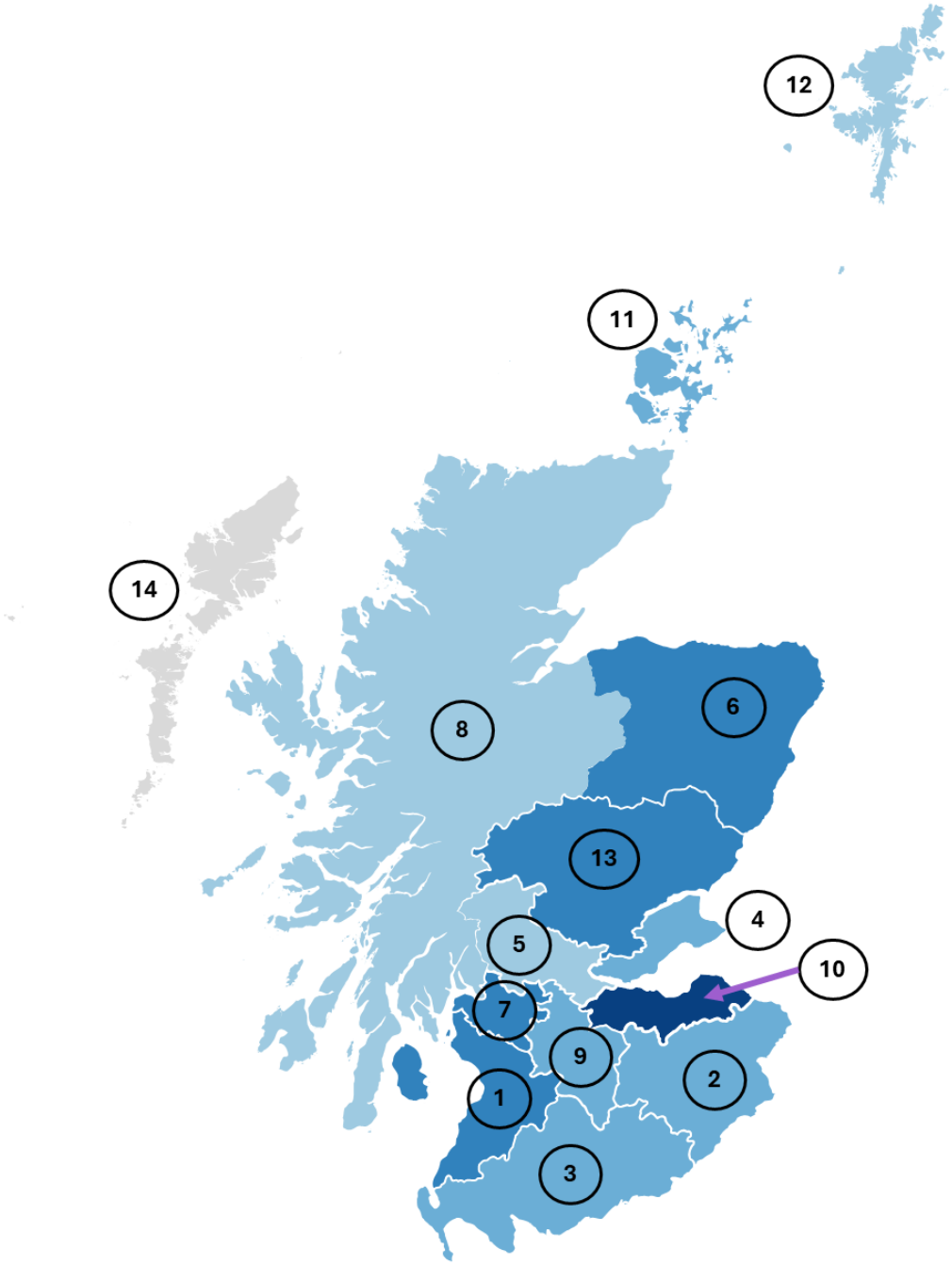
- reduce length of hospital stay
- reduce reliance on pharmacological interventions, and
- reduce falls.

During the recruitment phase (September-October 2024), 113 applications were received for the programme from care home and hospital teams. Following panel discussion, 55 teams met inclusion criteria: 28 care home teams and 27 hospital teams. Hospital teams represented a mix of settings and specialties including specialist dementia units, community hospitals, and acute hospitals (elderly medicine, orthopaedics, admission and assessment wards). Care home teams represented a mix of large, small, health and social care partnership and private providers of adult and older people's care homes.

The map on the next page shows the spread of teams across Scotland, with boards numbered as in this alphabetical table.

	NHS board area	Care home teams	Hospital teams
1	NHS Ayrshire & Arran	3	2
2	NHS Borders	2	1
3	NHS Dumfries & Galloway	2	1
4	NHS Fife	3	1
5	NHS Forth Valley	2	0
6	NHS Grampian	2	3
7	NHS Greater Glasgow and Clyde	3	3
8	NHS Highland	1	1
9	NHS Lanarkshire	2	1
10	NHS Lothian	4	8
11	NHS Orkney	2	1
12	NHS Shetland	1	0
13	NHS Tayside	1	5
14	NHS Western Isles	0	0

NB: No applications were received from NHS Western Isles



Number of teams	Colour on map
0	Grey
1-2	Light blue
2-4	Blue
5-6	Medium blue
7+	Dark blue

Self-evaluation findings

During the first 4 weeks of the improvement programme, teams used the Reducing Stress and Distress Self-evaluation Tool to assess their current practice against six quality criteria and identify priorities for improvement. Each quality criteria were broken into sub-criteria that were rated on a scale of 1-6. This scoring aligned to that used by the Care Inspectorate. The quality criteria were:

1. Early identification and assessment
2. Person-centred care plans
3. Meaningful activity
4. Continuous intervention/one-to-one observation
5. Involvement of unpaid carers
6. Staff training and knowledge

Variation was evident across all six criteria. Teams scored highest for **early identification** and **person-centred planning**, particularly around effective information sharing and coordinated care planning. **Meaningful activity** and **continuous intervention/observation** received the lowest ratings, followed by **unpaid carer involvement** and **staff training**. Staff training showed the greatest variation, with scores ranging from 1 to 6 across teams. The lowest-rated areas overall were **confidence in delivering trauma-informed care** and **awareness of processes to support meaningful activity**.

Some differences between settings were clear. Care homes tended to score themselves more highly, while hospital teams applied lower ratings more consistently across the tool, reflecting differences in setting and care delivery and familiarity with self-evaluation scoring.

Teams responded positively to the self-evaluation process, noting benefits such as stronger multidisciplinary collaboration, space to share perspectives, development of clearer improvement aims, and recognition of existing good practice. They also highlighted the time commitment involved and the value of working through the tool collectively.

> *"*The self-evaluation process helped focus us on an improvement plan to reduce stress and distress. It was great to see the multidisciplinary team come together to work collaboratively on a targeted goal."
>
> Participating team feedback

> *"*It has given the group time to reflect on current practice, what works well [and] what doesn't. Focused our mind on areas of improvement."
>
> Participating team feedback

Improvements tested

Following identification of improvement priorities, teams then developed and tested change ideas to achieve their local improvement aim. Change ideas were spread across the quality criteria, however the highest number were related to meaningful activity and person-centred care plans (see figure 2). Some teams looked at change ideas that could relate to multiple criteria, such as using Getting to Know Me to inform person-centred care planning, and meaningful activities.

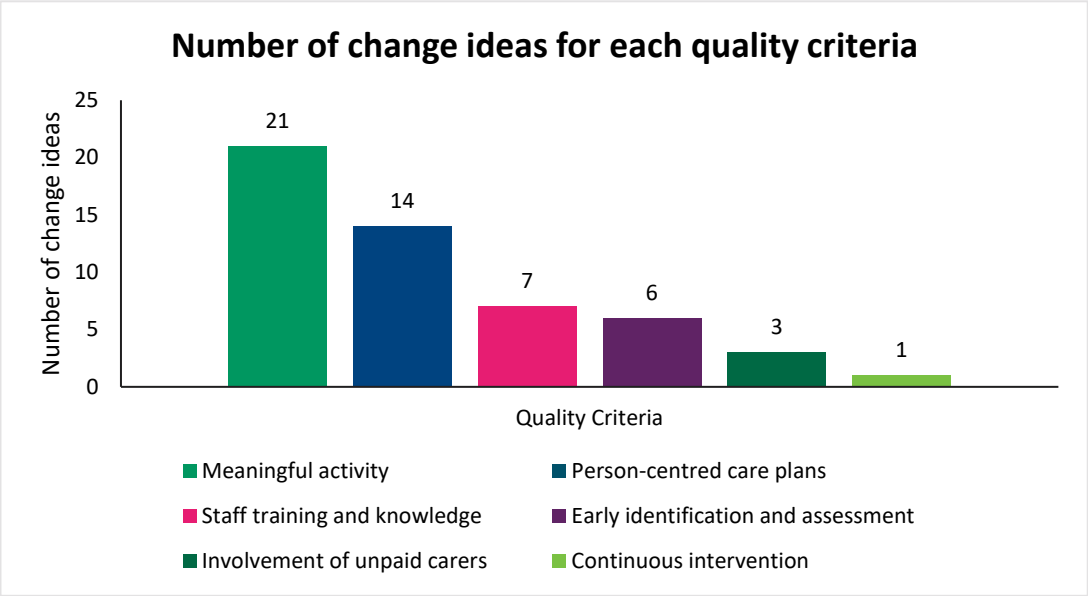


Figure 2: Bar chart showing number of change ideas for each quality criteria

Examples of change ideas developed by teams include:

- To enhance meaningful activity and connections, one care home created a dedicated staff role focused on engagement and interaction with people living in the home.
- To build staff confidence and knowledge in responding to stress and distress, one hospital team introduced weekly peer support sessions to share experiences and reflect on practice.
- To strengthen unpaid carer involvement, one hospital team introduced structured family and carer meetings two weeks after admission. These meetings reviewed the completed Getting to Know Me document and informed person-centred care planning and meaningful activities.
- One care home introduced monthly reviews to identify activities that were meaningful to each resident and incorporated these into individual care plans.
- One hospital team worked with the local NHS Dementia Consultant to identify staff learning needs and develop a tailored training programme.

The change ideas identified have been developed locally to meet the improvement aims identified. There may be opportunity for spread and scale however it is recommended teams use the self-assessment tool to identify the improvement priorities for their own service.

Impact of improvement

While formal data collection is still developing, teams consistently report meaningful improvements in residents' and patients' wellbeing, staff confidence and quality of care. The following examples combine early quantitative evidence with powerful stories of change from teams who have tested and sustained new ways of working.

Early impacts

- Reduced stress and distress across care home and hospital settings.
- Reduction in use of PRN (when necessary) psychoactive medication across multiple teams.
- Fewer falls, supported by both recorded and anecdotal evidence.
- More person-centred care through meaningful activity, Getting to Know Me and family involvement.
- Improved staff confidence, skills and wellbeing in supporting stress and distress.
- Better experiences and outcomes for patients, residents, families and unpaid carers.

Evidence shows that a reduction in pharmacological interventions, reduction in falls and improved person-centred care can result in decreased length of hospital stay[1], so if the improvements above are sustained we would expect to see evidence of this in participating sites.

Impact stories

A medicine of the elderly ward in NHS Dumfries & Galloway introduced a checklist to enable early identification of factors that can contribute to stress and distress. They used this information to create person-centred support plans for patients at risk of stress and distress and support improved activity and engagement on the ward. This has reduced incidence of stress and distress, lowered use of PRN psychoactive medication and improved patient and carer experience, while boosting staff confidence. The model has since spread beyond the ward, influencing practice across the local system.

> *"I was feeling down all the time, and the staff had me feeling more cheerful every day."*
>
> Patient feedback

[1] Sanatinia, R., Crawford, M.J., Quirk, A., Hood, C., Gordon, F., Crome, P. et al. (2020) *Identifying features associated with higher-quality hospital care and shorter length of admission for people with dementia: a mixed-methods study.* Health Services and Delivery Research, 8(22).

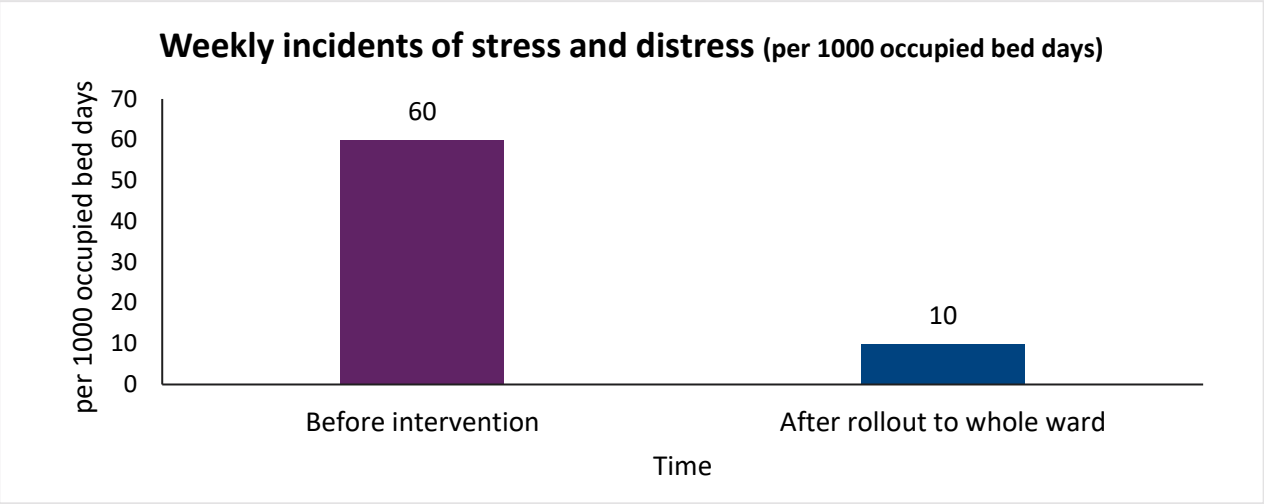


Figure 3: Bar chart showing number of weekly incidents of stress and distress

The team at a care home in Fife transformed the experience and wellbeing of their residents by rethinking evening routines and creating a calmer, more connected lounge environment. Small, resident-led changes supported by a consistent staff presence led to improved sleep, social engagement, and confidence, and contributed to a clear reduction in falls within the home.

> *"Residents are now spending more time in the lounge and are forming friendships and connections with each other."*
>
> Staff feedback

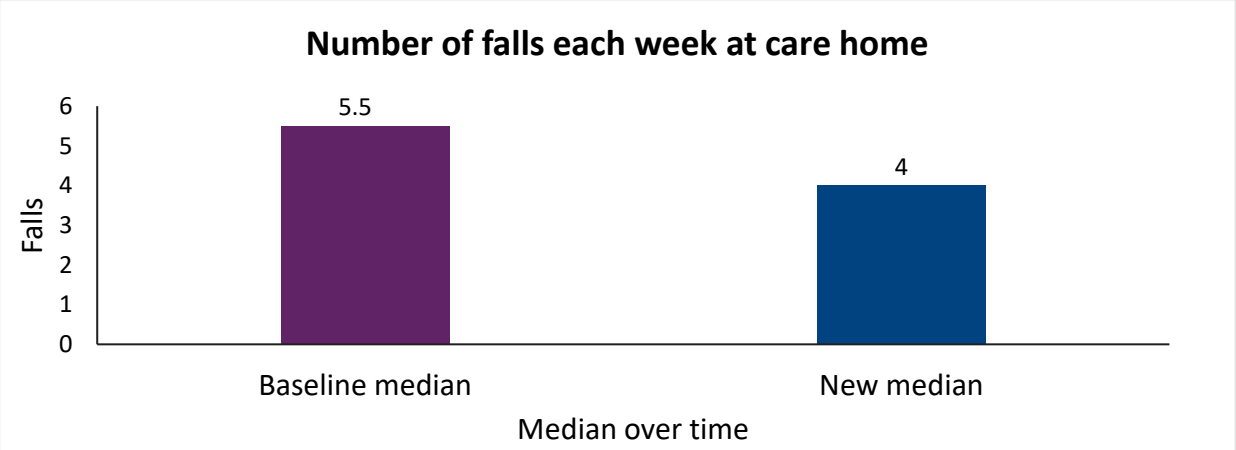


Figure 4: Bar chart showing number of falls each week

A hospital team in an orthopaedic ward in NHS Tayside have strengthened engagement with families from the point of admission, using Getting to Know Me forms to capture person-centred information. This information is used to offer meaningful activity on the ward, and a dedicated activity trolley has been created to support this. Their approach has been shared across the NHS board through a short learning video, and the project lead was shortlisted for a Scotland's Health Award.

"We have been delighted to see some of the improvement in activity on the ward and the other members of the team becoming more involved since noticing the improvement."

Staff feedback

Creating sustainable impact

Across different settings, teams are showing that meaningful improvements begin with understanding what matters to the people they support. The stories and early data highlight person-centred changes are reducing stress and distress, strengthening relationships, and creating calmer, safer environments. Teams are learning from each other through collaborative learning sessions and are being supported to sustain and spread their improvements where possible.

While it is too early for many teams to demonstrate impact on outcomes for people living with dementia, we are continuing to capture this learning, which will be shared through case studies.

Key learning on programme delivery

Several activities were carried out to evaluate programme delivery. This included monitoring attendance and progress of participating teams, and semi-structured interviews both with participating teams and the three organisations delivering the programme. This highlighted the unique strengths and challenges across sectors enabling the delivery team to make several recommendations and to adapt the approach for future cohorts.

Delivery of 12-week approach

Participating teams completed a 12-week quality improvement programme combining group learning sessions, one-to-one and group coaching calls, and a site visit. Care home teams were supported by a lead coach from Care Inspectorate and hospital teams by a lead coach from Healthcare Improvement Scotland. The first 4 weeks focused on self-evaluation, followed by 8 weeks to develop and test improvement ideas. After completing the programme, teams joined the Reducing Stress and Distress Collaborative, with access to learning sessions every month and ongoing support. Follow-up coaching calls were added to the programme after identifying challenges associated with the short, 12-week timeframe and the level of support still required.

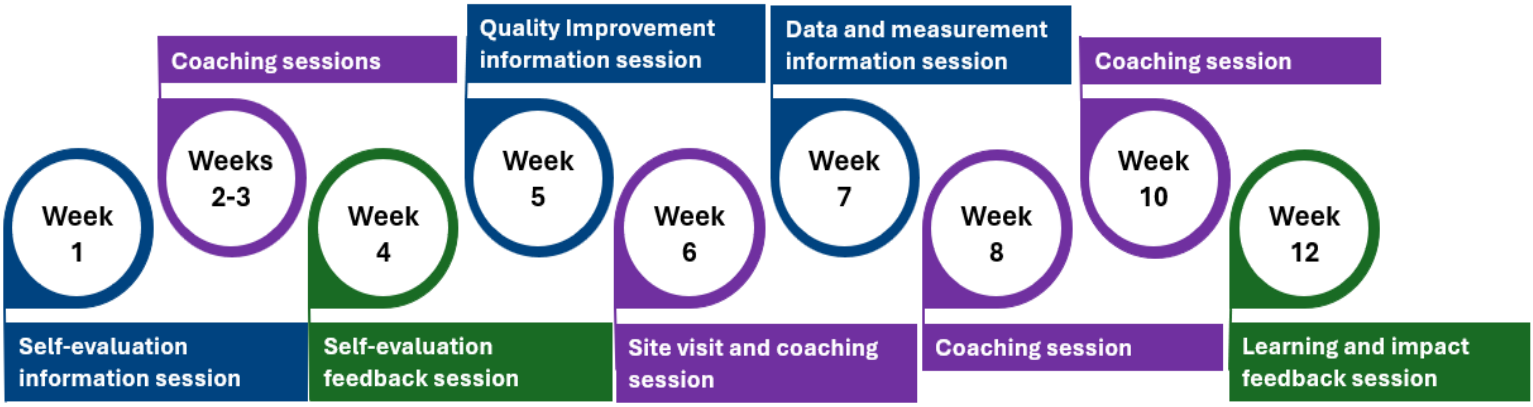


Figure 5: 12-week timeline of improvement programme activity

Participation and progress of hospital teams

Hospital teams demonstrated a strong commitment to the 12-week programme with 88% attendance across learning sessions. Shift patterns were identified as having the biggest impact on attendance. Engagement declined during the follow-up period, with fewer teams continuing to take part in coaching calls beyond the initial 12 weeks.

Progress along the quality improvement journey was monitored throughout the programme and follow-up. The 12-week approach proved successful – 97% of teams reached the stage of testing improvement ideas. Due to the short programme timeframe and reduced engagement during the follow-up period, few teams advanced beyond this point. A small number of teams submitted data to evidence the impact of their changes and reached the point of considering spread and

sustainability. Key infrastructures within hospital settings supported progress, such as access to quality improvement support and NHS Dementia Consultants.

Participation and progress of care home teams

Teams demonstrated strong commitment to the 12-week programme with 68% attendance across learning sessions: a significant decline in engagement was noted during the follow-up period. Teams highlighted staffing challenges as a significant factor in preventing ongoing engagement. It is also recognised teams initially committed to a 12-week programme, with no clear expectation that staff would attend and engage in follow-up activities.

63% of care home teams reached the stage of testing their improvement ideas. The pace of the programme, due to the short timeframe, was identified as a significant factor. Due to competing demands on the workforce some care home teams fell behind, which led to challenges in maintaining momentum and motivation. Despite offering reassurances, some teams began withdrawing from activity.

Experience of participants

Across the four cohorts, participants consistently reported positive experiences of the programme. Feedback was gathered throughout, including during learning sessions, follow-up reports, and through an independent evaluation conducted by Healthcare Improvement Scotland's evidence and evaluation for improvement team. Collectively the feedback highlighted that teams were motivated, supported, and challenged by the work, despite significant operational pressures.

Most teams reported feeling apprehensive at the beginning of the programme, as well as feeling hopeful and excited to get started. Many reported they did not get as much done as they had hoped by the end of the programme due to staff shortages and other pressures. Ultimately, teams were hopeful they'd be able to continue the work following the end of the programme.

What worked well

Learning sessions: The structure of the programme helped teams feel less overwhelmed. Participants highlighted the weekly focus areas and small-steps approach made the work feel achievable.

> *"*The small steps, having each week identified as an area to focus on X Y or Z, prevented the project from being overwhelming."
>
> *"*It had made it clear to me what to focus on as I was thinking too big, so can start small but still make a difference."

Peer support and learning: Teams reflected that coming together for learning sessions and hearing from peers facing similar challenges was reassuring.

> *"Everyone seems to be in similar positions with staffing challenges and time constraints, so it is helpful to assure us that we are not lagging behind."*

Team working: Several teams described the programme as a catalyst for improved multidisciplinary collaboration.

> *"*[Our ward] have really enjoyed working together as disciplines on the one project. We feel it has really brought everyone together in becoming more stress and distress focused."
>
> *"We've really made a point to take a multidisciplinary approach which has led to lots of great ideas."*

Staff confidence and motivation: Teams identified increased confidence in implementing improvements within their service.

> *"The team have worked hard to deliver meaningful improvements and are now influencing practice across the wider organisation in supporting scale up and spread."*
>
> *"Happy with how the staff have driven their ideas forward, and the outcomes for the residents."*

Challenges

Time commitment: the time needed to participate in the programme was highlighted as the most significant barrier. Staff shortages, shift patterns, and limited protected time affected teams' ability to fully engage. Some teams struggled to involve wider staff groups for the same reasons. One interviewee suggested participants should be made more aware of the time commitment needed. Others recommended recording presentations for staff who could not attend; this was implemented for all subsequent learning sessions.

> *"*Ward has been very busy; time has been limited however making small progress."
>
> *"Happy to have got to the point we have despite all the difficulties we have had with staffing and workload."*

Independent evaluation interviews

The independent evaluation echoed themes highlighted in feedback collected during the learning sessions. The quality of teaching and learning sessions, support from the programme facilitators, the provision of practical tools (such as the self-evaluation tool), and the value of small group sessions were all discussed during interviews as part of the independent evaluation.

Interviewees emphasised benefits for people living with dementia and for staff.

> *"The outcomes for the residents have been amazing, it's made a massive difference."*
>
> *"We feel better, more strong, more equipped to support people with stress and distress."*

All interviewees said they would recommend the programme to others. The evaluation methodology can be found in the appendix.

Partnership working

An internal evaluation was conducted to capture learning about the novel way of working across three partner organisations. Thirteen people were interviewed: five from the Care Inspectorate, seven from Healthcare Improvement Scotland and one from NHS Education for Scotland.

Overall, the programme was viewed positively, particularly for its multi-agency collaboration, complementary organisational strengths and the level of workforce support provided. Challenges included capacity constraints, IT barriers, and cultural and organisational differences.

> *"*It's been a really nice example of three partners working together… you don't see that very often, particularly between health and social care."

What worked well

Cross-organisational relationships and learning: strong relationships developed across the programme, increasing trust, mutual respect, and shared understanding of challenges across hospital and care home settings. This led to more diverse and robust planning of activity.

Building on unique strengths improved the quality of the programme.

- Care Inspectorate strengthened the language, and accessibility of materials for care homes.
- NHS Education for Scotland contributed expertise in education, training development, and learning culture.
- Healthcare Improvement Scotland brought project management support, enabling the development of infrastructure and resources such as handbooks.

Shared learning opportunities: both care homes and hospital wards benefitted from seeing shared challenges and solutions. All participants benefitted from building local connections across health and social care. The collaborative approach provided wider networking opportunities with stakeholders.

Challenges

IT issues: technology was a major barrier that impacted on delivery organisations and participating teams. Care Inspectorate staff had initial challenges to access MS Teams that impacted on opportunities to collaborate. Many care homes lacked reliable access to MS Teams, preventing them from fully participating in learning sessions. From cohort 2, sessions were set up and delivered in smaller groups, which provided a more equitable experience.

Developing shared approaches: establishing common ways of working across partner organisations required an adjustment period. New reporting structures, such as coaching logs and data workbooks, were introduced and gradually embedded into practice.

Language: developing resources and course content using a shared language that was appropriate across health and social care settings caused delays and required significant early investment to ensure success.

Next steps

The programme has proved successful in supporting hospital and care home teams to identify and test improvements to support people living with dementia who experience stress and distress. The short timeframe significantly impacted teams' ability to demonstrate impact of change, and to consider spread and sustainability. The joint delivery approach has created a unique programme, providing the opportunity for shared learning, while ensuring the provision of high-quality support addressing the unique opportunities and challenges within hospital and care home settings.

Based on the learning highlighted in this report, the Reducing Stress and Distress Improvement Programme has been redesigned for 2026.

- In recognition of the challenges identified around a short 12-week timeframe, the programme now offers 12 months' support. This enables teams to progress through the whole quality improvement journey: to develop, evidence impact, spread and sustain their improvement ideas. Learning and coaching activity is spread across this longer time frame.
- Information shared during the application process clearly outlines the activity and time commitment of teams to participate in the programme to ensure clear expectations are set.
- To limit IT challenges and encourage peer support and learning the programme is delivered in small regional groups. This was identified as crucial for the programme to be a success.
- Data collection is a mandatory component of the programme. Teams are supported to collect baseline data from the first month, to overcome data collection challenges and ensure teams can understand and evidence the impact of improvement.
- All presentations at learning sessions continue to be recorded in recognition of challenges with staffing and shift patterns and to enable flexibility around attendance.

The programme continues to evolve based on learning, using a reflective practice approach to all activities by hosting debriefs after events and learning sessions, and using support calls each week for coaches to surface any lessons learned.

Since the evaluation, collaboration between Care Inspectorate, Healthcare Improvement Scotland and NHS Education for Scotland has strengthened, with clearer structures, shared processes and more consistent communication. This includes a shared communications plan, a collaboratively designed coaching handbook and regular leadership meetings to discuss challenges and opportunities. The organisations are now better positioned to support participating teams and maximise impact.

Appendix

Evaluation methodology

Healthcare Improvement Scotland's evidence and evaluation for improvement team conducted an independent evaluation of the improvement programme. The purpose of the evaluation was to understand participants' experiences of the programme, identify enablers and barriers to engagement and explore perceived impacts on staff practice and outcomes for people with dementia.

Design and approach

The evaluation used a qualitative design, drawing on semi-structured interviews with staff from participating teams. This approach was selected to allow participants to describe their experiences in depth and to capture a range of perspectives across different settings.

Participants

Six staff members took part in the evaluation. Participants represented four hospital teams and two care home teams. All participants were directly involved in delivering or supporting the programme within their service.

Data collection

Interviews were conducted online using Microsoft Teams. Fieldwork took place between April and July 2025. A single evidence and evaluation for improvement team researcher conducted all interviews to ensure consistency. Interviews followed a semi-structured topic guide, allowing for both comparability across participants and flexibility to explore issues raised by interviewees. The interview schedule covered:

- expectations and early experiences of the programme
- perceptions of learning sessions and coaching support
- use of programme tools and resources
- barriers and enablers to participation
- perceived impact on staff, teams, and people with dementia, and
- suggestions for improvement.

A copy of the interview questions is available on request.

Data analysis

Interview data were analysed independently by the evidence and evaluation for improvement team researcher using a thematic approach. Transcripts and notes were reviewed to identify

recurring themes, areas of divergence, and illustrative quotations. Emerging findings were discussed within the evaluation team to ensure rigour and consistency.

Governance and ethics

The evaluation adhered to the Healthcare Improvement Scotland Research Governance Policy. Participation was voluntary, and all interviewees provided informed consent. Data was anonymised during analysis and reporting to protect confidentiality.

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