Make my day: the impact of Creative Caring in older people's care homes

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Esmée Fairbairn FOUNDATION

Creative Carers

The Baring Foundation

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This report has been submitted to an independent assurance assessment carried out by The SROI Network. The report shows a good understanding of the SROI process and complies with SROI principles. Assurance here does not include verification of stakeholder engagement, data and calculations. It is a principles-based assessment of the final report.

Summary

Creative Carers is a training programme developed over seven years that instils a broad approach to creativity in older people's care homes, so that day to day lives are more fun and engaging. In turn this leads to better staff and resident morale and better engagement between the two, which leads to better care and more demand from families of older people for places in the home.

Scope

Creative Carers is operating within a fast changing demographic context with life expectancy in the UK increasing at more than five hours a day[1]. Alongside customer and policy demands for personalised care, and with nearly a million people living or working in care homes[2], it matters that we get this right.

Five care homes participated in funded Creative Carers training delivered by Suffolk Artlink, from May 12 to May 13. Suffolk Artlink wanted to use Social Return On Investment (SROI) analysis to test if this was the best delivery model for care homes to buy.

SROI is a method defined by two overriding principles, that we value what really matters – especially to the people involved, and that we are very careful not to double count or over-claim impact. The process starts with establishing a Story of Change then collects evidence for that change. We establish how much of that change was due to Creative Carers, and then value both the outcomes and the investment to establish value for money recommendations for improvement.

Early on the need for a new delivery model started to emerge, so this report turned from an evaluative report into a forecast. We tested and planned the new model thoroughly with stakeholders and this analysis is for a new year-long programme with impact over two years.

Consultation

Care home staff, residents, families and the artists were consulted to establish the story of change, and later the evidence for change. Some of this was directly at training events, and the home also distributed surveys to staff, residents and families. Over the year we established that the people who matter are the care homes as businesses, the residents, their families and the artists. Future research into the role of health and social care colleagues is recommended.

The Story of Change

SROI uses a 'Story of Change' to anticipate what we practically and thoughtfully invest in the programme, the model of delivery and the difference we expect it can make to all those involved.

[1] Academy of Medical Sciences, 2009

[2] JRF, 2010

The tested model needed updating, as unlike previous years, homes saw themselves as already creative. To make a bigger difference the new model will train the whole home in creativity. The manager must be involved from the beginning, using a diagnostic with the artist to develop their own bespoke programme based on individuals' starting points. The artist will stay with the home over nine months in a new creative coaching role. New training materials will help to clarify how 'Creative Caring' fits into processes such as induction and supervision.

Creative Carers differs from other care and arts sector models. In a complement to Eden Alternative training for example, Creative Carers is practical, allowing carers to practise creativity and imagine themselves in residents' shoes. Unlike many arts interventions, it is training rather than a participation project. As one regional manager says,

> ***"I don't see Creative Carers as a project, I see it as changing the way we work."***

As well as the financial investment, Creative Carers has some thoughtful, tested principles. Whilst the quality of artistic input is at its heart, it values process over the end result and the everyday space as much as the art room. Whilst reminiscence might be a starting point a focus on the present is important.

And whilst being flexible and responsive to residents' needs, the approaches are also carefully planned and paperwork kept to share with others. All of this needs skilled artists experienced with vulnerable people and must be helped along by the manager so it can become absolutely business as usual.

The training programme

Training builds on seven years of experience that focus on personal change for the care staff involved. New training objectives and materials will link the training to care home procedures such as induction and supervision. Each home will receive bespoke training identified through the new diagnostic tool developed by the lead artists.

The lead artist trains the whole home over two days, with the delivery artist in attendance. This uses structured questions to turn an everyday object into a creative journey. For example an artist ***"asked residents what a cushion was and one answer was 'comfort'".*** Exercises start by developing care staff creativity. Over the day they focus in on care home delivery.

The delivery artist goes onto support the home over nine months, by phone and on-site for three sessions, either running the sessions or supporting staff to run sessions themselves. This includes planning and reviewing sessions.

Networking, sharing and whole home change are in the hands of managers.

The difference Creative Carers makes

The care sector is a complex market, and it is important to understand the different motivations of these stakeholders in analysing the benefits of Creative Caring.

The idea at the heart of Creative Carers is that creativity generates more caring, by getting people involved and getting them to know each other. So the key to Creative Carers is mutual but different benefits for residents, their families and staff, where more creative encounters lead residents to become more mentally active and independent. This aligns with the Social Care Institute for Excellence's (SCIE) definition of excellence in social care, which identifies 'spending time purposefully and enjoyably doing things that bring pleasure and meaning' as one of four elements of excellence[3]. It means staff time can be better spent, on getting to know residents and their needs or on other home developments. Once a significant number of people are involved, the new way of working becomes the norm and better care becomes visible to staff, residents and families, with relationships and peace of mind improving as part of a virtuous circle. Finally the approach develops artistic practice in a very caring way.

The research showed no negative impact from Creative Carers, but it is limited by the resistance of some carers and residents. It should be carefully targeted within the home, with the former group needing careful management so a tipping point can be reached and change to the whole home embedded. Some residents will continue to prefer their own company, and they should be supported in their choice.

In summary, the outcomes are:

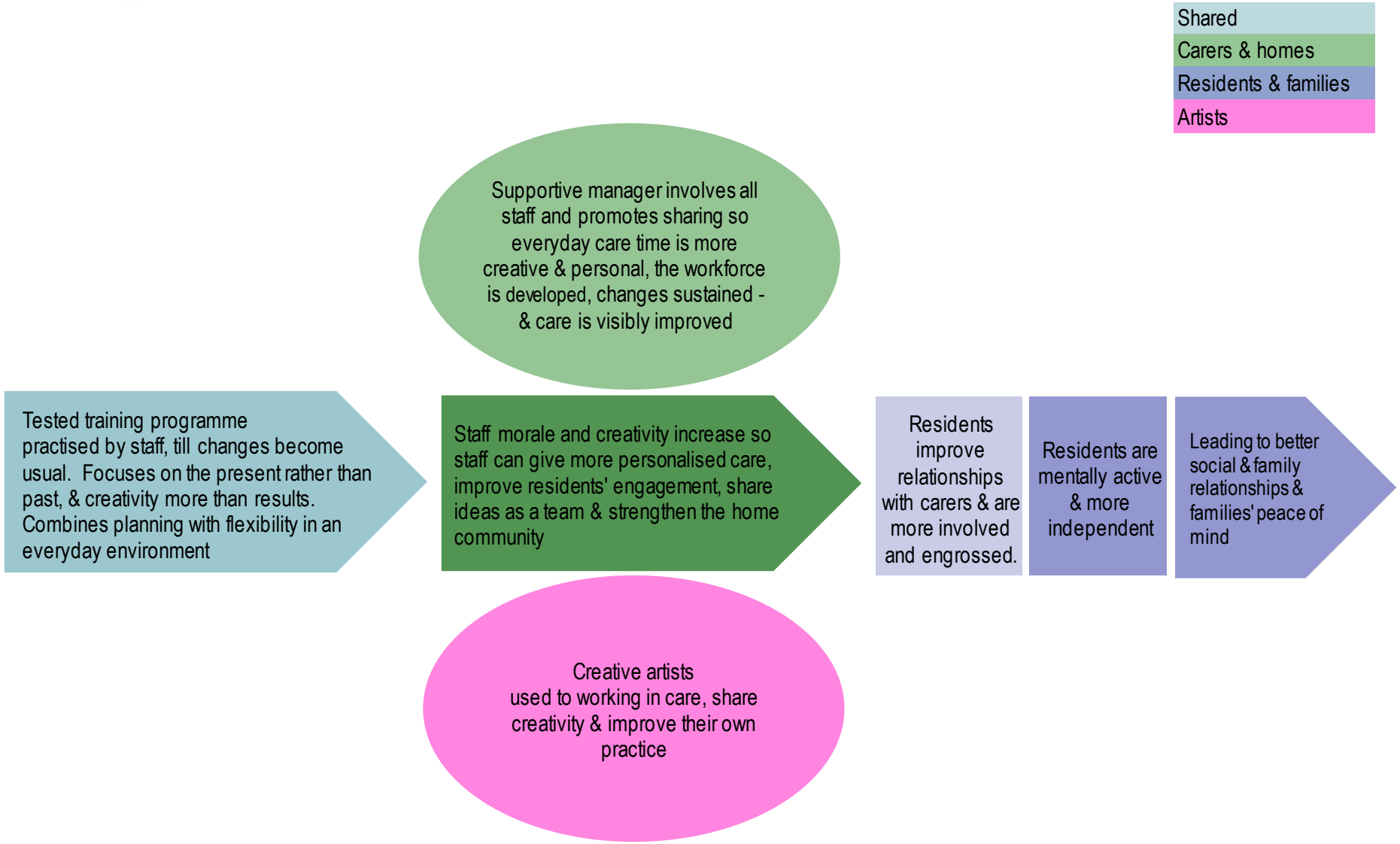
- Residents are mentally active and more independent
- Residents have better social and family life
- Families have more peace of mind
- Families get on better
- Care is more creative and personal
- Sustained workforce development
- Better long term care of residents visible to staff & families
- Artists re-think, re-value and improve this and other creative practice

Outcomes which could be further researched include:

- Physical benefits to residents
- Changes to demand for health and social care services

[3] Commissioned by the Care Quality Commission, 2011

Summary story of change



Evidence

Evidence that things had changed in the tested model was collected through interviews, workshops, informal and formal observation, surveys, and behaviour monitoring. We had to cater for residents with dementia and Dementia Care Mapping (DCM) proved very useful with other residents too. It was used to predict behaviour and mood change, which was then confirmed by staff monitoring changing demands from residents. Surveys were less successful because of the lack of control over implementation, but interviews and observation throughout provided very rich material.

DCM predicted a change for most residents, with a minority making significantly fewer 'contact' calls and a few joining in more obviously with social activity. Fewer contact calls will release many hours of staff time for proper engagement and for other training – a constant need for homes. All the homes interviewed experienced whole-home change, even though the whole-home training had not yet been put in place. We forecast significant impact on families, mostly through peace of mind. Artists felt limited impact though, because this programme focused on the demand rather than supply of Creative Carers, so our forecast for them is cautious. The challenges in collecting evidence we describe can be simply addressed in the new model.

Impact

After gathering evidence, we tested what Creative Carers could take credit for. In an enclosed environment, change can be put down to what happens within that environment. In this instance other training and development accounting for over two-thirds of the impact on the home itself, whilst for the residents there is a small effect from going out too. A typical resident care home stay is two years, and we expect benefits to residents to last through that time. In a successful project which embeds Creative Caring, home changes will be superceded by other factors sooner, such as more training or policy changes, limiting what Creative Carers can claim.

In the long term, the programme could make a difference to the local care market, and the effect on demand from families and for health and social care services should be researched.

Social Return On Investment

Because SROI intends to show value for money, including social value, it quantifies both the investment and the benefits or 'returns' using either financial values or where there is no obvious market value, proxy values. It also means we can compare different benefits. Some ways of establishing proxy values are: what else might the person spend money on to achieve the same result? Or how much of something are they willing to give up to achieve the result? Or what else in their life (that we do know the value for) do they prioritise above or below our outcome? We used all these approaches, as well as some academic research to estimate values.

There are two important stakeholders for Creative Carers, the homes and the families (including residents). Value to the home is tangible and can be represented by business spend with the

most important being the use of staff time. Values for residents are more intangible, 'social' returns. They may look high – but these are emotive issues involving vulnerable people and caring is generally under-valued.

Investments over the year by the home are the cost of training, £2,786, and staff time at just over £2K making £4,813 in all. For families the investment is unseen, but we include the proportion of their fee that goes on staffing and activities at around £450 a week each; in all over £12K a year. In total there is an investment from all stakeholders of just under £17K.

£50K of business and social value is created overall making a return of 1:3. Testing various scenarios and values most frequently shows a return of between 3 and 4 and we are confident the value is within this range.

The benefit comes from eight key outcomes, two for residents, a corresponding two for families, (lasting two years but with 82% of the impact attributed elsewhere) three for homes (the first lasting two years, the others one year with 72% attributed elsewhere) and one for artists – which is an area for growth. Attribution is high because homes tend to be involved in a lot of other training and development.

- **Residents become more mentally active and independent**. Around three-quarters of residents (24) experience the benefits of more creative everyday caring. From our DCM mapping we see that 'creative behaviour' increases by about 20% with mood enhanced by around 50%[4]. Staff then observed ongoing behaviour change, finding that on top of the wider affects, a small minority (3) experience a big change. Where before they might make ten calls just to make contact with staff, relationships become more engaging and subsequently they might make one or two calls.

  The outcome is valued in terms of the independence for residents that results; equivalent to what an older person might spend on home adaptations, home help and taxis in order to stay at home, amounting to over £8K. Because in the model we need to take off a significant amount for the effect of other factors, in this case other training by the home, this amounts to just short of £17K overall.

- **Residents have better social and family relationships**. A further small number (5) appreciate the more creative approach to activities and start to join in more in groups, seeing better relationships as a result. This is a cautious way of quantifying this outcome as the previous group also have improved relationships, especially with carers, but we are taking care not to double count.

  Research shows relationships are what older people appreciate most[5], so we've used a high research value of

[4] Dementia Care Mapping formally observed participants' behaviour and mood in everyday and activity caring. Combined with national research which establishes the positive knock-on effects of creativity, and with staff observations confirming changes, we used the results to predict the benefit.

[5] e.g. JRF, 2011, Bowers et al, 2009 and Williamson, 2010

£15.5K[6]. Because we've taken care not to double-count with the above, and with considerable other attribution this amounts to around £4K of value.

- **Families have more peace of mind.** For residents who become more mentally active and independent, we forecast that around half of families (those who visit at least weekly) will feel greater peace of mind and a sense of restored order. As one daughter said, ***"I've got mum back".***

  We used willingness to pay a top up fee as a proxy value, of over £8K a year[7] and £11K in all.

- **Families get on better**. Though there was a small change in this model this is a high value result, well worth developing. As one visitor says, ***"I love him more than anything, but he doesn't know who I am."***

  This generates a value based on lost earnings of someone prepared to look after a parent at home of £15.3K[8]. Overall, the return is over £4K.

  (It is worth noting that whilst they were derived separately the family and resident values of individual and social outcomes equate closely, at around £8K and £15K).

- **Care is more creative and personal**. This is the highest value outcome for homes and a very tangible benefit. It results directly from residents' independence and is about reducing calls for contact, so that time can be spent instead on relationships which in turn improves care and enables staff to head off problems, or on other activities such as training. The value is based on the few residents experiencing a big difference and the majority a small difference. With each call taking about 10 minutes of staff time, around 1 hour 20 minutes a day for the minority and around 20 minutes for the majority can be saved.

  Over the year, at £7.20 per staff hour saved, the value of this can mount up to around £13.7K for the home.

- **Sustained workforce development**. The cultural change is perhaps underplayed in this model, because delivery of the whole home approach has not yet been tested. Nonetheless the four homes we interviewed agreed there was a home wide change.

  We've valued this at the lowest discussed value of £1,400, what one home spends on bonuses to motivate staff (although other homes would value this change much higher, for example as a hike in staff pay of £13,500). As a result of the high attribution to other training programmes, there remains a small value in the hundreds. We keep it in the analysis though, as an integral part of the virtuous circle of improvement.

- **Better long term care of residents visible to staff and families**. The success of care homes depends entirely on

[6] Powdthavee 2007, Putting a price tag on friends, relatives & neighbours

[7] Indicated by care home managers

[8] PSSRU, 2009 Unit costs of health and social care

reputation through customers' experience and word of mouth, so visibly improved care is a real benefit.

It is valued at £3,000, what a care group might spend marketing a poorly performing home. Again, with caution in forecasting the whole-home model, this results in value of under £1K.

- **Artists re-think, re-value and improve this and other creative practice**. Because this particular programme focused on the delivery model for homes, development of artists took a back seat. In spite of that, artists agreed that Creative Carers had affected their daily practice and good quality artists are vital to future delivery.

  Five artists were involved, and the value is equated to CPD gained in a £300 workshop at £750 overall, but should be grown in future models.

Recommendations

Having created the Impact Model, we tested different scenarios, and with the feedback from care homes conclude with these recommendations:

Delivery

- Maintain experiential learning for carers, a focus on empathy with residents and other principles of delivery.
- Develop and make best use of artist time in the home.
- Bespoke training for each home.

Evidence

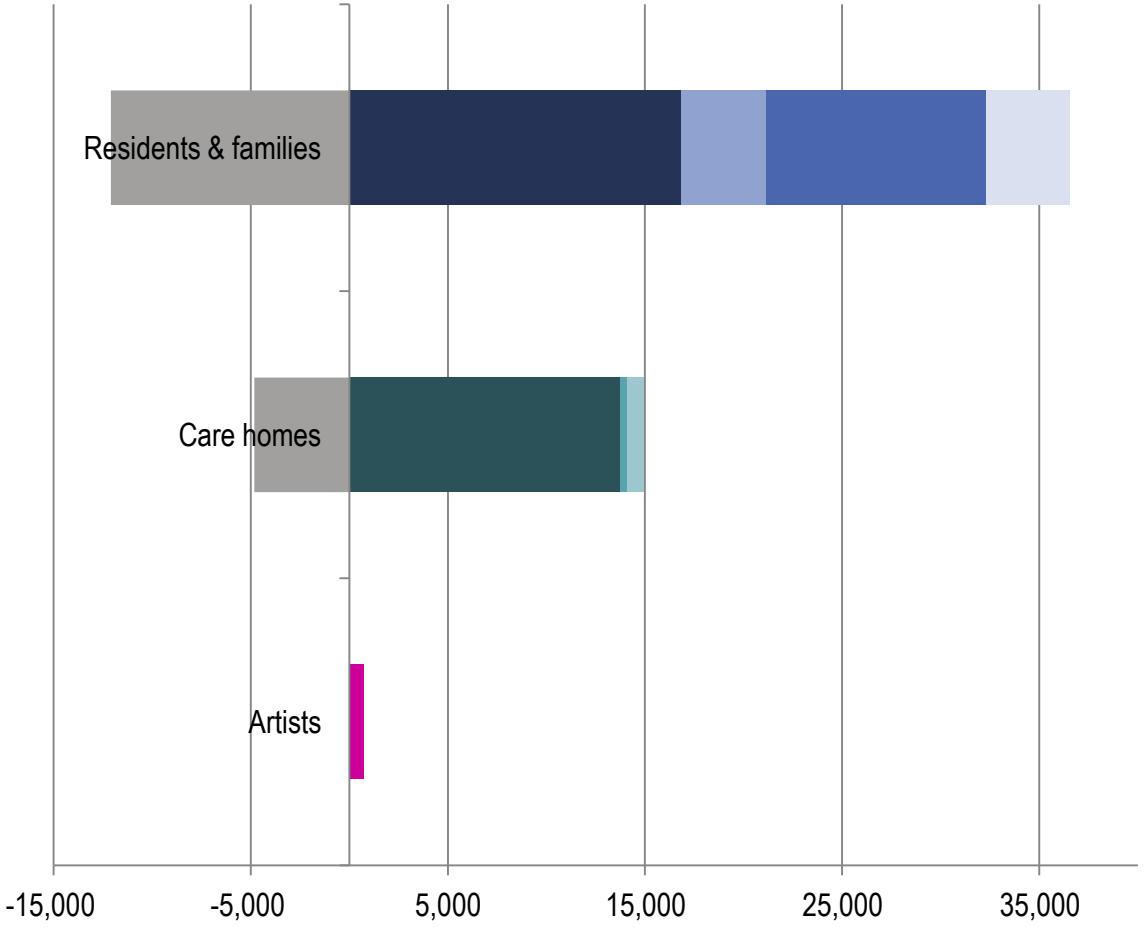
- Include a creative baseline test for staff in the training, and train activity co-ordinators to repeat it. Encourage homes to use DCM.
- Continue to collect subjective evidence including surveys before and after training.
- Collect more objective evidence. Include observation of contact time and health needs in materials and monitor family demand and willingness to pay for care services. Assess new national research into mental as well as physical health in assessing Quality Adjusted Life Years.
- Involve visitors and residents in validating findings.

Impact

- Explore the Story of Change more including whole system change with colleagues from health and social care. Explore the difference between social and individual benefits for residents through social and individual creativity. Test the effect on physical outcomes too.
- Focus the diagnostic and training design on the key outcome of making care more creative and personal, including targeting key staff and residents.
- Test delivery models for homes with different starting points.
- Continue to test values and impact with awareness of the complexity of the care market for homes, families and public services.

Figure 1 Total investment and return

Total investment	**16,912**
Total return	**49,896**
Return on investment	**3 to 1**
Residents	
Residents mentally active	16,847
Residents better relationships	4,288
Families	
Families & residents investment	-12,099
Families peace of mind	11,199
Families get on better	4,222
Care homes	
Investment	-4,813
Care is creative and personal	13,742
Workforce development	328
Better visible care	833
Artists	
Investment	0
Artists improve practice	750



Full report

Background

Creative Carers is a training programme for older people's care homes. It was devised and developed by Suffolk Artlink in partnership with the artists Caroline Wright and Helen Rousseau. The programme is featured in the Baring Foundation's good practice report *Creative Homes*, 2011.

In spring 2012 Suffolk Artlink was funded for the seventh year of delivery by Rayne Foundation. It also secured funding from Esmée Fairbairn to use this round of delivery to get onto a more sustainable footing by clarifying the best way to deliver the training and by showing its impact. This work has been commissioned from MB Associates who are analysing the social and business return on the investment.

Context

Creative Carers is operating within a demographic context which is fast changing, and amidst policy and customer demands for personalised care. The care sector is a complex market. Care homes are highly regulated, but competing in a responsive labour market. Families care profoundly about quality, but their choice is limited by older peoples' need for stability. The public sector has complex responsibilities, split between health and social care. But with nearly a million people living or working in care homes, it matters that we get this right.

Demographic context

Life expectancy in the UK is increasing at more than five hours a day, every day[i]. The growing population of older people means that one in 24 is now 80 or over and by 2050 that will be one in 10[ii]. By 2021, it is expected that almost a million older people will have dementia[iii].

Life expectancy in our society is defined as the number of years lived without illness or disability, bolstered as it has been by improvements in medicine and technology. By contrast most people's expectation of life would include company, pleasure and purpose as well as years of life. As families disperse, this leads to a narrowing life with more isolation and loneliness for individuals. Whilst severe loneliness has remained constant in those over 65, the number of people who are 'sometimes' lonely has doubled from around 15% to 31% in the 1990s [iv] [v].

For society, the challenge of an aging population has become more important with the financial crisis and rise in youth unemployment putting pressure on intergenerational relationships. The Young Foundation asks who wins the jobs that are available and who takes priority in receiving limited state resources, for example?[vi]

Policy context

At a state level, this growth means a likely social care funding gap of £1 billion by 2014[vii] - the OECD claims that Britain faces one of the biggest care bills in the industrialised world[viii]. This is alongside the responsibilities of the health sector towards an aging population.

So it's not surprising that there is a general move towards helping people help themselves, using their strengths, assets and networks to guard against the need for expensive 'care'[ix].

One of the answers to this challenging context is to support 'active aging'[x] of which participatory arts through Creative Caring could be a part. To concentrate attention on the scale and immediacy of the challenge, the European Commission designated 2012 the year of Active Aging.

The Government's White Paper on public health in 2010 committed to enabling older people to take an active role in community life, and to participate in education, leisure and cultural activities. With the personal and political in mind, the UK's Dilnot Commission reporting in 2012 had as its aim to make social care both fair and sustainable. In 2013, the Care Bill stated that the recommended cap on what individuals have to pay for their care would be introduced. Although set higher than recommended by Dilnot, it will nonetheless leave local authorities to meet the rest of care costs. It also focuses on an 'asset-based' approach - building on the positive.

Business context

The care sector is highly regulated, but with nearly half of care home places purchased privately, and a rise of 40% in one year using direct payments for personal budgets[xi], the pressure for personalised care comes from customers as well as policy. Much of the research done into the role of the arts and creativity has been about arts and health. But these customers include the ill, those with long term conditions *and* the healthy.

Residential settings are not hospitals, but nor are they hotels. They are home to around 440,000 people in Britain[xii]. In addition, care homes employ 355,000 care staff[xiii]. With other support staff, that's not far short of a million people either working or living in older people's care homes. So getting the approach to care right is well worth the effort.

At present 82% of National Care Forum members deliver arts activities with a delivery budget of between £100 and £5,500 a year. A lot of these are based on reminiscence and most have music and movement sessions. 11% are initiated by residents[xiv].

To meet growing demand, improve older people's lives and address the challenges for the state, care homes will want to be competitive in the labour market. The Mental Health Foundation recommends that care home staff are skilled up to undertake participatory arts with older people. In doing so, care homes can offer satisfying work and personal and professional development to attract more staff and even volunteers and families to help deliver better care.

On the demand side, the trend towards person- centred care can make a big difference to peace of mind for families. But normal customer choice is limited by high personal risk, meaning they are unlikely to ‘shop around’ – choice of home is often limited by the urgency of the need, and once residents are in a home, only extreme circumstances would prompt a move.

Creative Caring offers a ‘win-win’ opportunity, by helping homes to compete for good staff and families in their search for quality local care. The trend towards person-centred care is an opportunity. One approach gaining a lot of ground, and used by several of our research homes is Eden Alternative. Eden Alternative is a philosophy that aims to transform institutional approaches into caring communities, ‘where life is worth living’. Another organisation sharing the market with Creative Carers is Ladder to the Moon, which develops organisations to be creative, fun and activity-focused. We explore how Creative Carers differs from these approaches below.

Scope

Five care homes participated in funded Creative Carers training delivered by Suffolk Artlink, who wanted to use Social Return On Investment (SROI) analysis to test if this was the best delivery model for care homes to buy. Early on the need for a new delivery model started to emerge. We continued to research the delivered training model, whilst consulting throughout on the new model which we forecast in this report.

Purpose and scope

The purpose of this Social Return On Investment (SROI) analysis is to establish clearly the business model for delivering Creative Carers, and so be able to make the case to care homes that they should invest in this non-mandatory service. It also hopes to enable Suffolk Artlink to influence agendas and add to the evidence base for the arts and older people sector.

The analysis assessed delivery of a training programme to five new care homes between May 2012 and May 2013, based on seven years of development of the approach. Early on in delivery we discovered that the model needed updating in the face of huge changes in demographic, business and policy contexts. Throughout the year, we consulted with stakeholders at every stage about how this new model might work, whilst collecting evidence from delivery of the existing model. We are therefore more confident than we would usually be that the forecast is robust.

This SROI analysis is a forecast of the new model. It explores the investment by care homes in one 'round' of training delivered over approximately a year[xv] and shows results lasting over two years, the average stay for an older person in a care home.

Social Return On Investment

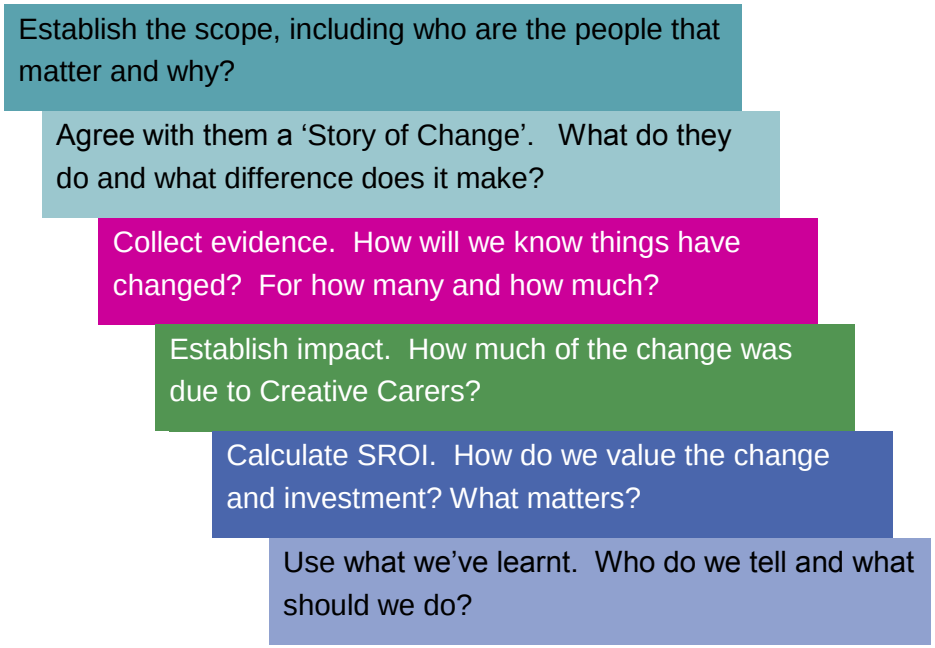
Social Return On Investment analyses combine a story about the difference we make with number values so things can be compared. Unlike other evaluations, SROI measures the knock-on effect of services, both beyond the obvious beneficiaries and into the future. It also accounts for what partners or others contribute, discounting an element for which the service can't take the credit.

Building on cost-benefit analyses, the SROI approach shows value for money in terms that go beyond the financial. It assesses a 'triple bottom line' of financial, social and environmental returns and compares them with cash and other investments to create a ratio.

SROI was pioneered in San Francisco a little over ten years ago and came to the UK shortly after. An international SROI network was established, and a framework was agreed in 2005. The first guide was then published with the support of the UK Cabinet Office, and with strong input from the Treasury in tune with their Green Book guidance for

assessing government spend. An updated guide is available at www.sroi-uk.org.

There is a set of principles for SROI work. First we involve the people who matter to understand what changes, and value the things that matter to them. Then we take a careful approach to only include what makes a difference, avoid over-claiming and be clear and transparent. We check back with stakeholders throughout, and finally use the SROI network to assure the report. There are six stages:



SROI analysis is not easy. The methodology can be time-consuming, and it needs a systematic and thoughtful approach. In this analysis the work was challenging, because it had a particular business focus, and was commissioned by one sector (the arts) in the main for another (care).

There is some scepticism about SROI, mostly where the final ratio is over-emphasised, but also because we have to use proxy values where there is no obvious financial value. Nonetheless, with proper ongoing consultation, it provides managers with invaluable information on what people value and generally uncovers priorities not identified by other evaluations.

Participating homes

The training was agreed by regional managers in two care home groups in East Anglia. None of the care homes had previously been involved with Suffolk Artlink or Creative Carers, though some used other creative techniques.

Three care homes from Greensleeves care group in Lowestoft and Ipswich participated, Harleston House, Broadlands and Thornbank. These are dementia care, residential and mixed homes respectively. Two care homes from Sanctuary care group in Harwich and Ipswich participated, Don Thompson House and Shaftesbury House, both in the main residential.

All these homes had the full training delivered and four remained involved and committed. Two, Harleston House and Shaftesbury, agreed to collect detailed evidence. One, Thornbank, was perhaps the strongest supporter of the programme, but because the home was involved in other research could not take on this task.

The people who matter

Central to SROI methodology is understanding all the people who matter in the Story of Change, whether they experience the change or are responsible for making it happen.

The research was undertaken with these people who were directly involved in the training:

- 14 care staff trainees
- Other care staff in homes
- Five care home managers
- Two regional managers
- Residents in five homes, amounting to over 100 residents and their families
- Five artists (two lead and three delivery)

The new delivery model will provide training for all the staff in a home, so the forecast predicts the impact on one care home through a combination of the results of our research and care home estimates. The programme costs - training the artists, developing new materials and managing the programme, are split over five homes. The forecast is for:

- One care home; all its staff (accepting a small group of about five resistant staff) including the manager and non-care staff
- 27 (from results of our research) out of 32 residents (the national average for a care home)
- half the families of 27 residents
- five artists (two lead and three delivery artists)

We expected that residents and families would be the main beneficiaries, and this was established through the analysis.

We were unsure whether carers would be primary or secondary beneficiaries. Throughout the programme it is clear that impact on the carers is central to all other outcomes – without them personally taking on-board a new type of creativity there will be no effect on residents or care homes more widely. Whilst we initially thought this might be a personal benefit to them (re-awakening their creativity), in fact the outcome is a professional one, enabling them to provide better personalised care. Whilst it's important for whole-home change that this improves morale and team work, the significant benefits are really to the home.

At scoping we also felt there might be a benefit to the whole care system by reducing need. But throughout the consultation this was not raised by stakeholders. The outcomes established relate to better quality of life rather than the physical benefits which might reduce health service demands. Our conclusions are similar to those of another report on the benefits of end-of-life training[xvi] which concludes that there is preventative value in better care in homes, but

there will only be cash savings if there are associated reductions in admissions to hospital.

There are two reasons why we recommend that this needs longer term analysis within Creative Carers. Firstly, we have been unable to fully test the physical impact of Creative Carers which might reduce the impact on the health service. But secondly, the radical change in the quality of care described could lead to real shifts in demand – both increased acceptability of residential care and potentially longer life so longer stays. In addition with around half of care home places purchased by local authorities, and the driving imperative of the context described above, savings to the health service could be offset by more and longer demand for residential care.

Finally, we envisaged that the artists themselves would benefit and Suffolk Artlink would be able to raise its profile and influence the arts and older people's sectors. Creative Carers does have the quality and integrity to do this, but in this model it is under-developed.

The imperative for Suffolk Artlink at the time of scoping was to make a persuasive business case so that care homes would commission the training. Artist development was not central to this. In future more strategic activity by Suffolk Artlink should develop the benefits for artists by working more in-depth on the creative coaching role with them.

In summary, the people who matter in this forecast are:

- Care homes and their staff – especially managers as leaders and the everyday behaviour of care staff
- Residents and families who visit
- Artists who develop and deliver the programme

Others who should be further researched are

- The whole care system, including local authorities and health service colleagues
- Artists who deliver new programmes with more focus on professional development

Consultation

There were four stages to learning from stakeholders[xvii]:

- The **stakeholders and expected outcomes** were established in a scoping meeting with the client and lead artists. The expected outcomes are recorded in the appendices.
- Stakeholders were consulted to establish a **Story of Change**, including at all of the training and other Creative Carer sessions. Because there were no learning objectives in place, we were able to ask open questions of trainees (artists and care staff) about what they wanted to get out of the training, and what difference they thought it would make to them, the homes and to the residents.

  Because the training was behind the scenes and not apparent to residents and families, artists and care staff were asked about the impact on them as the training rolled out. Their views were then tested in surveys.

  During this consultation phase, it became apparent that a new whole home model was necessary to make a difference in homes where practice was already effective. This meant that whilst the evidence was collected using one model, we continued to consult about new plans throughout the year.

  The consultation to establish the story of change was as follows:

  - Evaluators consulted with 5 artists during training
  - Evaluators consulted with 14 care staff during training
  - Artists provided feedback from five sessions in each of five homes
  - Evaluators observed sessions in four care homes
  - Evaluators observed two training sessions with managers
  - Evaluators consulted with two homes (four staff) at a sharing day

  The written Story of Change document was tested with care home managers, and again at a valuation workshop held with managers and activity co-ordinators. This was intended to put values to the agreed Story of Change, but comparing and positioning the effects in priority order helped us rationalise the outcomes. One to one interviews throughout gave managers the opportunity to report challenges, negative outcomes or unexpected affects.
- **Evidence** was collected to test the Story of Change. This included surveys with staff, residents and families, interviews with managers and Dementia Care Mapping in two homes which was used to observe behaviour and mood change in those without dementia too (described

in the evidence section below). Through interviews and surveys designed to quantify the change, the outcomes were also refined.

The evidence collection was as follows:

- Evaluators collected baseline information from care staff during the initial training
- Two homes agreed to detailed evidence collection, including a staff survey circulated by the evaluators. One completed the baseline and both completed the follow up survey after four months. 10 staff from each home responded
- Dementia Care Mapping was completed by Suffolk Artlink staff three times in one home and four times in the other to test 'everyday care' and activity care before and after four months
- Staff in the two care homes observed 16 residents for behaviour change
- One home collected surveys circulated by the evaluators from 8 residents before and after four months
- Two homes collected surveys circulated by the evaluators. One completed the baseline and both completed the follow up survey after four months. 18 family members responded.
- Evaluators interviewed five care managers face to face before the roll out and four managers by phone after six months.
- Five artists were email surveyed by the evaluators after a year.

o Through establishing an Impact Model the stakeholders and their outcomes were tested to ensure they were both still relevant and significant so that only those that really mattered were included.

The **materiality and verification** process was as follows:

- Two managers and two activity co-ordinators from the two homes attended a valuation workshop.
- Evaluators interviewed two managers in detail to agree the Impact Model. A further one manager commented on circulation of the Impact Model.
- Evaluators interviewed one regional manager
- Reports were circulated to care homes for comment

Story of Change

The Story of Change explains what is invested in the programme, the model of delivery and the difference we expect it can make.

Delivery and investment

The tested model needed updating, as unlike in previous years, homes saw themselves as creative already. To make a bigger difference the new model will train the whole home in creativity. The manager must be involved from the beginning, using a diagnostic with the artist to bespoke their own programme based on individuals' starting points. The artist will stay with the home over nine months in a new creative coaching role. New training materials will help to clarify how Creative Caring fits into processes such as induction and supervision.

As well as the financial investment, Creative Carers has some thoughtful, tested principles. Whilst the quality of artistic input is at its heart, it values process over the end result and the everyday space as much as the art room. Whilst reminiscence might be a starting point a focus on the present is important. And whilst being flexible and responsive to residents' needs, the approaches are also carefully planned and paperwork kept to share with others. All of this needs skilled artists experienced with vulnerable people and must be helped along by the manager so it can become business as usual.

The Story of Change was initially outlined by the lead artists and Suffolk Artlink, and then updated at the artist and carers training, valuation workshop, in interviews and observations over the whole period[xviii]. Having been tested over years, we are confident that the broad approach and commitments are the right ones to deliver the forecast outcomes.

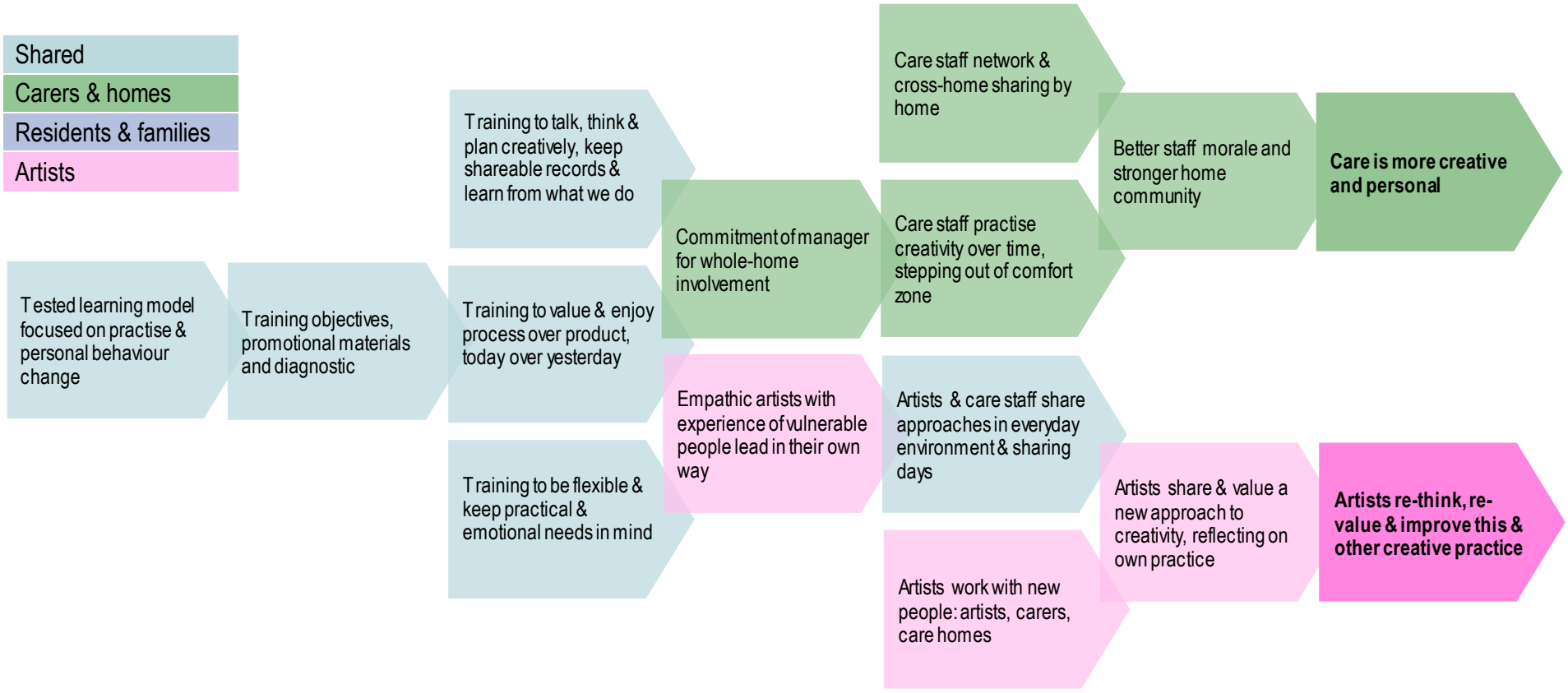
But unlike previously, in 2012, participating care homes were creatively experienced, and were already very focused on personal care in tune with the Creative Caring ethos. As one delivery artists described, ***"It is obvious that they are good so I adopted a position where I tried to present and develop more abstract thinking in each exchange - some felt challenged by this but not overwhelmed."***

Coupled with tight delivery budgets, ***"four hours of contact time with the carers is not really enough to build the trust and rapport necessary to get people to relax, build bridges / trust and learn"***, ***it*** looked like the programme might have a limited affect. In fact the results were good, but in future we need to be sure we can make a difference with this higher baseline. Rather than paring back costs, a new delivery model was develop which will focus on getting the whole home involved so creativity becomes part of everyday caring.

Comparing delivery models; the programme run 12/13 and two new delivery models

	Model delivered May 12/May 13 researched in report Five homes, two care groups	New model devised during May 12/May 13 and forecast in report One whole-home (x 5 homes)	Alternative new model Three local homes (x 3 groups)
Promotional and training materials		New promotional materials explaining training objectives and a behaviour and culture change basis to the training. These will be aligned to recruitment, induction, supervision and training practice in homes. The programme kicks off with a 'diagnostic' described below.	
Leadership and diagnostic	(see manager involvement below)	Essential involvement of manager and/or deputy manager from the start. New creative diagnostic tool to establish whether the home is beginning its creative journey, or already creatively competent and which individuals to target. The artist spends half a day working with the manager to build a relationship and the diagnostic can inform the training programme.	
Artists	Two lead artists train delivery artists for half a day.	Lead artists train delivery artists including new skills in 'creative coaching' for their long term relationship with the home.	
Delivery to homes	Lead artists deliver one training day to a mixed group of carers off-site.	Lead artist delivers whole-home training for two days in care home so all staff trained. Delivery artist attends half day to meet trainees.	Lead artist delivers two days of training to three care homes who come together at one of the homes. Delivery artist attends half day.
	Three different delivery artists work alongside carers for four sessions in care homes. One carer-led session is observed by artist.	One delivery artist works alongside staff for three sessions in each home over nine months. The artist manages communications and bookings and has a new creative-coaching role. Staff and the artist plan together when they are confident to start delivering themselves.	
	The mixed group has two sharing days, one six months later.	Sharing is led by the care homes in their home group or throughout the home.	
	Five managers trained by lead artists in two half day sessions.	(see manager involvement above)	
Cost	£1,739 per home for five homes	£2,786 per home for five homes	£1,537 per home for nine homes

The new delivery model



Forecast:

New diagnostic
New artist training/role for five artists
One care home participates

32 care staff trained over two days

Home or regional manager involved
One consistent delivery artist

Nine months support & 3 sessions from artist on-site
Home organises own sharing

Benefits develop

Leading to outcomes

Tested learning model focused on practise & personal behaviour change

The original delivery model which ran from May 12 to May 13, and two new models are compared above. The preferred model, which this analysis forecasts, is for one whole home to be trained together.

Feedback shows that Creative Carers is a training and learning model that works. As a manager says, "***it provides a valuable aspect of training, and the external input is appreciated."*** It differs from other care and arts sector models. In a complement to Eden Alternative training for example, Creative Carers is practical, allowing carers to experience and practise creativity over time, and imagine themselves in residents' shoes. Unlike many arts projects it offers workforce development rather than one off participation.

This everyday creativity is designed to create deep and long-term change. It is extremely important that the home manager supports and understands the training programme and the motivations of trainees.

Maslow's model below shows how people starting a learning journey may not know or accept they need to change. They learn and practise their new skills, and begin to see how creativity can make their job easier and more enjoyable. But to create long-term change the way of working needs to become second nature, or practice is likely to slip back.

Managers need to create the impetus for change with some resistant staff (managers report around 1 to 5 staff in this group), make sure all staff have the time and space to practise their new approaches, and create sustainable change by embedding the new ways of working in supervision and other processes. The longer involvement with the artist will support this.

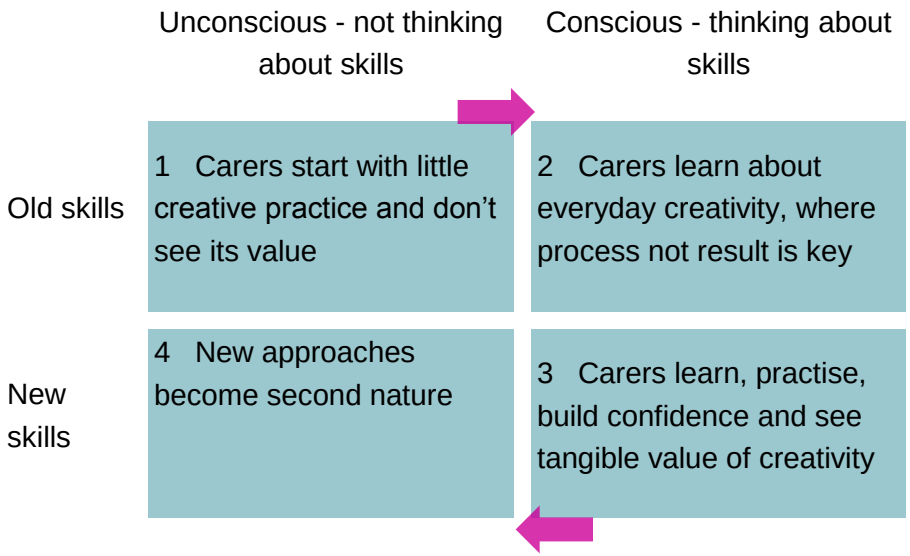


Figure 2 Conscious Competence learning for carers

Training objectives, promotional materials and diagnostic

New promotional materials will be put in place which explain the scope for impact and the training objectives so homes know exactly what they are signing up to. They will be linked to homes' day to day staffing procedures to help with embedding including recruitment, induction, supervision and other training practice.

The training will now be bespoke, with control in the hands of manager or deputy manager right from the start. A new creative diagnostic tool will be devised to help managers in deciding who should be involved and how, based on the behaviour change model shown above. It will identify those who don't yet know they need to change, and make sure new working practice becomes thoroughly embedded. It will also identify residents that the home wants to target - those who are least fulfilled but most demanding on staff time. It will ask:

- how creative are we and do we want to be?
- who do we need to work with, both staff and residents?
- how do we best engage them?
- what is the home context and networking and sharing environment?

The delivery artist will spend half a day working through the diagnostic with the manager and planning the training.

The training programme

There are five artists involved in the training, two lead artists who have developed the programme over seven years, and three delivery artists.

The lead artist delivers training to the whole home over two days so that all staff can be involved. The delivery artist attends for half a day, and continues to support the home for nine months through three on-site sessions and phone contact. All the training and support is delivered in the workplace, with off-site sharing in the hands of the manager.

Creative Carer training offers tools for ideas stimulation and strategies for the generation of creative ideas, practical advice in the home context, the ability to empathise with residents and experience of planning, delivering and reviewing creativity.

It is aimed to empower carers and furnish them with the tools needed for their own personalised activities using what's to hand in their place of work. What the programme does not do is provide the materials and skills for a prescribed set of activities. In this way the training is easily adapted to carers workplaces and residents and trainees are more empowered. For those who are less confident in their own creative ability, the programme provides a set of tools to create a portfolio of ideas, often drawing on personal knowledge which in turn forms a growing information resource.

The training uses a structured set of questions and observations to explore and develop creative ideas around an

(everyday) object. The trainer demonstrates the planning of a workshop/activity that could be adapted to suit different residents with particular needs. An example set of observations surrounding a random object is shown in the following table:

Object	Scarf
Size and shape	Long, thin
Material	Wool, silk, thread, fabric
Colour	Red and orange
Qualities	Soft, textured, warm
Uses	Warmth, covering up, fashion accessory
Alternative uses	Use as rope, unpick and re-make, fold, stitch, pleat
Associations	Winter, autumn, bonfires, skiing, coats, gloves

From developing care staff's own creativity, further exercises gradually focuses in on planning and delivering in the care home. The following workshop was one of many proposed from the above ideas.

In autumn, collect dry leaves and cover the floor of a room so clients can swish and crunch the leaves underfoot creating a distinctive sound and smell. The leaves can also be picked up and thrown into the air, giving clients the opportunity to feel the leaves in their hands. Accompany this with a reading of a poem by Keats – On Autumn and possibly extend this activity on a further occasion to include looking at images that employ autumn colours.

This basic workshop outline is sensory, uses literature that may have been studied by elderly people in their youth, allows residents restricted to the home to experience the sensations of outside and creates a visual spectacle. It is a strong starting point for other related activities such as creative writing, printmaking from leaves, knitting scarves, a visit to a wooded area, an autumn picnic and so on, which might be included in a further workshop or planned as a series of ongoing activities.

After the day of training the delivery artist will visit the home for three further sessions over nine months. These will be a mix of artist and carer delivery developed as they see fit. The visiting artist talks with the carer about workshop ideas and how they will be delivered. The care staff talk to the artist about residents' needs. Phone contact beforehand supports the planning and afterwards, the artist and carers jointly evaluate and write up the workshop. This allows the carers to witness the planning process of the artist, the execution of a session and the aftermath when much is learnt and noted for the future.

Both during and after artist-led sessions, carers begin to develop ideas for their own approaches, supported by the artist. This might include the optimum number of clients for a

session, clients' particular medical conditions, facilities, sourcing materials, length of session, and so on.

One trainee describes their experience:

> *"This has brought so much to the home. I went along with three other members of staff and on the day itself we really got what they were trying to do. At first I found it hard, I struggled to understand what they were trying to achieve but as the day went on I began to understand exactly what they were talking about. The way they've done it was in my opinion a really good way of going about it. We talked all the time about what is best for the residents and how to go about doing different activities with them. The Creative Carers made us all realise that what we see, touch and do in everyday life is different to what everyone else sees - you may see a red fluffy cushion but someone else will see it in a different way and the feelings & memories will be different for them as well.*

> *"The artists who came into the home were so good and really taught us art is not just painting and colouring things. The residents really enjoyed this and some, who would normally not of taken part in this kind of activity came down and joined in with everything, they still join in now. We started a project with them based on photos of the residents and this has been ongoing and always will be. We want the home to feel like a home, when you walk in the door you are able to say… Yes I live here. We have now taken it up a notch and for each area they are doing a 'family tree' of whose rooms are on that level, this has brought residents closer together as they speak about whose room are next to theirs and what photos they should use in that area, they are working not only as a team but as a family."*

Training to talk, think & plan creatively, keep shareable records & learn from what we do

The programme encourages carers to record and learn from their successes and challenges. Through the programme the carers learn to think, talk and plan creatively about how they can encourage imaginative things to happen. This needs to be shared in ways that work for the home so that the practice is sustainable, and over time spreads across the whole home. The artist will help the carer to complete a full evaluation of their Creative Caring.

Training to be flexible & keep practical & emotional needs in mind

At the same time as taking care to plan and record, Creative Caring needs to be flexible. Care homes are experienced in working with the complex or unexpected, with often unpredictable behaviour of residents and staffing structures based on shift work. Practical or emotional issues may mean plans need to be quickly revised. The examples in the artists' words in this report demonstrate how cleverly they use everyday situations to create a really challenging creative environment.

Training to value & enjoy process over product, today over yesterday

Key to the philosophy of the programme is that we value the process of creativity with older people over the end result, so that everyday caring becomes more creative, allowing 'everyone to take part whatever their level of competence and whether or not they have any previous experience'[xix].

> ***At Don Thompson, one artist worked on how to build on what already happens in the home – their bingo – developing words into symbols, drawings and shapes, so that the residents begin to own the idea and in time create the themes themselves.***

It challenges homes like one we heard from where "***'Creativity' only happens at Christmas, Easter and special occasions***." Many residents won't or can't come out or their rooms and those with dementia have challenges in accessing activities, so we need to make sure that they can benefit from this approach too. Whilst residents capabilities are different, their creative needs are very similar and devising approaches that work for those with most limitations provides a good discipline for making creativity accessible to everyone.

The focus is on today not yesterday so residents become mentally active and more independent. It is distinctive from reminiscence, though it may use life story work to trigger creative activities. It is important to know the participants, for example what job they did previously, or what abilities they have.

One elderly gentleman, Frank, proved that despite limited speech, he was a very capable artist and spent some time with a carer – who is equally capable – drawing things from his working life (as a tank driver in the war and latterly on trains). He concentrated intently for a substantial period of time and had a 'drawing dialogue' with the carer.

Artists work with new people: artists, carers, care homes

Sharing between artists and carers is essential for the artists' own benefit. Working with each other during the training, and in-depth with care homes provides them with an opportunity more profound than many participation projects.

Care staff practise creativity over time, stepping out of comfort zone

The training has at its heart carers' own creativity, in a way that helps them be in the shoes of residents. Creative Carers strengthens the 'soft skills' that research and feedback from older people show they value above professional skills[9]. For example one of the home's inspection reports residents' responses:

> ***We have a lovely bunch of carers."***

> ***The carers are very kind."***

> ***If I need help I just have to ask and they do it for me."***

[9] JRF 2011 *A Better Life*

Artists & care staff share approaches in everyday environment

More than one home described a beautiful art room that residents are unwilling to use. To make Creative Caring happen every day, the training focuses on staff's own creativity and everyday things. This can create big changes in a home.

> ***"Everything from the activities room is now out and around the place instead of being stored."***

Once the staff are trained, the artists will go into the homes three times to demonstrate or support the staff in practising what they've learnt. This is highly valued by the homes, as artists are seen by residents and staff as people ***'who know what they're doing'.*** They bring a very fresh approach key to the impact on the resident.

What the research says about principles of delivery

See appendix for a list of the main research documents used

Joseph Rowntree Foundation's (JRF) workforce report for residential care homes found that the model most preferred by residents emphasised compassion over knowledge and skills of carers. Although it had a very small training budget, one of the three pilots best met this need. It was also the one that had the most contented staff, and was the model 'championed' by the home manager, rather than an area manager or LA/PCT intervention. The report highlights the importance of sharing between different staff in creating organisational change.

Two reports provide 'tips' on implementing creative or personalised care, Baring Foundation's *Creative Homes* and The Young Foundation's *One Hundred Not Out*. The Baring Foundation report tells managers to get ready with careful planning and getting to know residents, and deliver through enthusiastic leadership and being ready to adapt. The Young Foundation report has an acronym SWAP – start with the person, wellbeing matters, an asset-based (positive) approach and prevention.

Another JRF report on what older people with high support needs value – *A Better Life*, reports that the researchers 'were struck by how important both the prospect and reality of meeting new people was for many'. This explains and backs up the enthusiasm residents felt for meeting Creative Carer artists.

Finally the Arts and Dementia Project assessed in 2011 by Northumbria University included within its main strengths flexibility and the quality of the artists. It cites a significant amount of evidence to suggest that creative activity provides a safe environment to experiment and meet new people, with something for participants to focus on together distracting them from negative thoughts.

Commitments and investments

Commitment of manager for whole home involvement

The programme will train all the staff in the home over two days, in the way that Eden Training[xx] or Ladder to the Moon do[xxi]. This requires considerable commitment from the home with the investment of time a substantial proportion of the cost, but will help to create the wholesale change that we want to see. It also recognises that creativity and empathy comes with the person rather than the role. Creative Carers are not just activity co-ordinators. This approach is about *all* staff taking *every* opportunity to make an encounter creative.

It can be challenging for some carers. One artist describes a conversation with a carer:

> ***"It wasn't until she did a session with the residents the following day when she asked them what a cushion was and one answer was 'comfort' that she truly understood what we were trying to convey."***

but the challenge is important to changing practice.

Empathic artists with experience of vulnerable people lead in their own way

The programme is delivered by empathic artists who are experienced at working with vulnerable people and skilled at devising activities, as one artist demonstrates: ***"I left the activity co-ordinator with 'touching bags', a set of flow diagrams and a list of ways to use the idea of building very slowly on what already happens."***

New training will be provided for artists to fulfil their 'creative coaching' role whilst building on their own creative practice. One artist will stay with the home throughout, to ***trust, build bridges, relax and learn*** with staff. This will make organisation easier too, as homes need to be flexible and arrangements often need to be changed.

The quality of the artists is very apparent to the residents and staff. Being treated as adults without limiting preconceptions was a real benefit to the people we heard from, and Joseph Rowntree Foundation (JRF) research shows the benefit of simply meeting someone new[xxii].

Care staff network & cross-home sharing by home

Sharing is very helpful, and needs to be 'owned' by the managers. To date, Suffolk Artlink has facilitated sharing sessions, but it is a challenge for care homes to come off site as they are frequently beset by emergencies. As this creates uncertainty ('will the other homes show up?') the sharing is better managed by the homes themselves. For example The activity co-ordinator from Harleston, planned sessions jointly with sister home, Broadlands and has also suggested they use their minibus to visit other care home groups.

With a bespoke training plan in place the home can support staff to share and learn from each other without depending on Suffolk Artlink or other homes. It can choose to target willing staff, or those staff who are resistant to change for example.

We have recognised this commitment of time in the investment the home needs to make.

With a whole home model, sharing is clearly easier to encourage. With a three-home model, the role of the area manager working together with the home manager is key.

Costs

All in all there is a considerable commitment required of time from the care home and that is valued in the section on investment below.

The cost of delivering a whole home Creative Carers training programme is £2,786, which as a charity Suffolk Artlink passes on at cost. The impact forecast in this report is for this model. The hope is that homes or care groups will see the benefits of the programme and buy the training, where before it has been funded by trusts and foundations.

An alternative model would be to deliver the training to fewer trainees from three homes in a local area at a cost of £1,537 per home. This allows a regional manager to purchase the package, but is likely to take longer to embed and it will be essential to ensure the home managers accept the commitment of time and support needed of them.

The difference Creative Carers makes

The idea at the heart of Creative Carers is that creativity creates more caring by getting people involved and getting them to know each other.

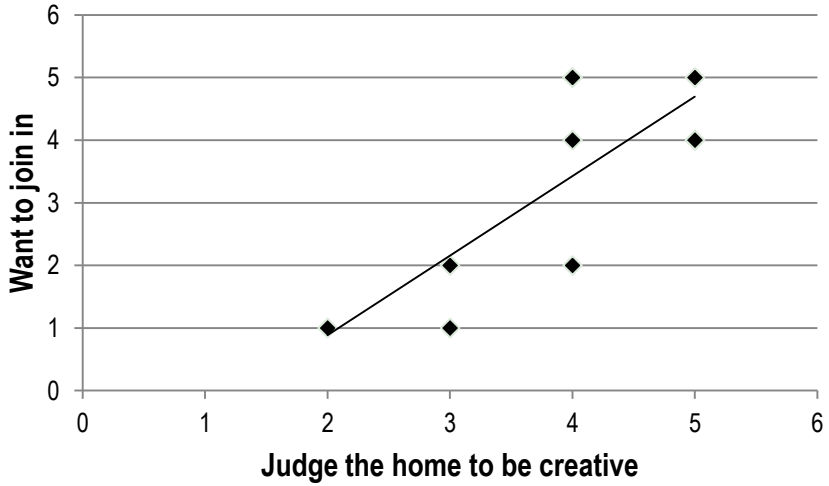
Testing the Story of Change

The logic of the Story of Change is that increased creativity is more engaging for residents, and more creative care staff will create better relationships and allow staff to anticipate needs. In turn this will lead to better care and less time wasted, leading to a better reputation and demand for the home.

Our survey showed that residents who felt the home was creative wanted to join in. The graph maps their scores for those two separate questions and shows an association (this was a self-selecting small sample so is indicative only).

Three-quarters of the way through the programme we ran a workshop with home managers and activity co-ordinators who confirmed that the logic of the Story of Change held up.

This was backed up by Dementia Care Mapping which we used to quantify the change, but also tested the rationale of the Story of Change. DCM maps both changes in behaviour and changes in mood. It showed that the new delivery model is creating different resident behaviour, which in turn is leading to better mood.



11 responses from residents

Figure 3 Residents survey results for 'think the home is creative' & 'want to participate'

These are 'leading indicators' for change. We recommend that delivery includes more collection of evidence using DCM and staff observations as described below.

What the research says about the case for creativity

The case for developing creativity with older people is explored directly by the Mental Health Foundation's (MHF) *Evidence Review of the Impact of Participatory Arts on Older People*, The Baring Foundation, and the Arts and Dementia pilot project in Northumbria.

MHF shows participatory arts can have an impact on mental wellbeing, physical wellbeing, communities and society. Most relevant to Creative Carers is for individuals: improved enjoyment, cognitive functioning, memory, creative thinking, self-esteem, and communication. And socially: more meaningful contact, friendship and support, a sense of community, broken down stereotypes and raised expectation about the quality of the care relationship.

This is backed up by the Baring Foundation, whose report says that participating in the arts can improve social wellbeing, physical engagement, the ability to concentrate, a sense of achievement, and personal expression - including hidden identities. In making the link with the workforce and breaking stereotypes, it also describes how the process can make others react to us differently, providing something to talk about and a new form of interaction.

Northumbria University's review of the Arts and Dementia Pilot project showed an impact on sense of belonging, relationships, confidence, enjoyment and happiness, energy and motivation. Some results were so profound participants began to think differently and to make real changes in their lives.

Other reports explore the *indirect* impact of creativity in terms of the self-determination or personal relationships which frequently result from creativity. In *A Better Life* for example, JRF describe

how a sense of achievement and self-esteem often come from participation in cultural activities and that people often invest emotional meaning in the everyday objects and places that Creative Carers are trained to use.

Creativity for the workforce is also explored. The Mental Health Foundation's literature review makes the case for skilling up the workforce to deliver participatory arts. Research has suggested that up-skilling care staff can produce benefits for residents in terms of improving quality of life, increased activity and stimulation, more positive interactions and relationships between residents and staff, as well as more appropriate and directed care [xxiii] [xxiv] [xxv].

JRF highlights the importance of having proper time for communication, which we expect to be generated by changing resident carer relationships from contact to relationships.

Outcomes for the people who matter

The key to Creative Carers is mutual but different benefits for families and homes. The care sector is a complex market, and it is important to understand the different motivations of these stakeholders in analysing the benefits of Creative Caring.

More creative encounters lead residents to become more mentally active and independent. This means staff time can be better spent, on getting to know residents or on other home developments. Once a significant number of people are involved, the new way of working becomes the norm and better care becomes visible to staff, residents and families, with relationships and peace of mind improving as a result and a virtuous circle created.

Finally the approach develops artistic practice in a very caring way.

The challenges of the approach is the resistance of some carers and residents, the former group need careful planning, and the latter need to be given supported choice.

In summary, here are the outcomes we see. The amount of impact is forecast below:

- Residents are mentally active and more independent
- Residents have better social and family life

- Families have more peace of mind
- Families get on better

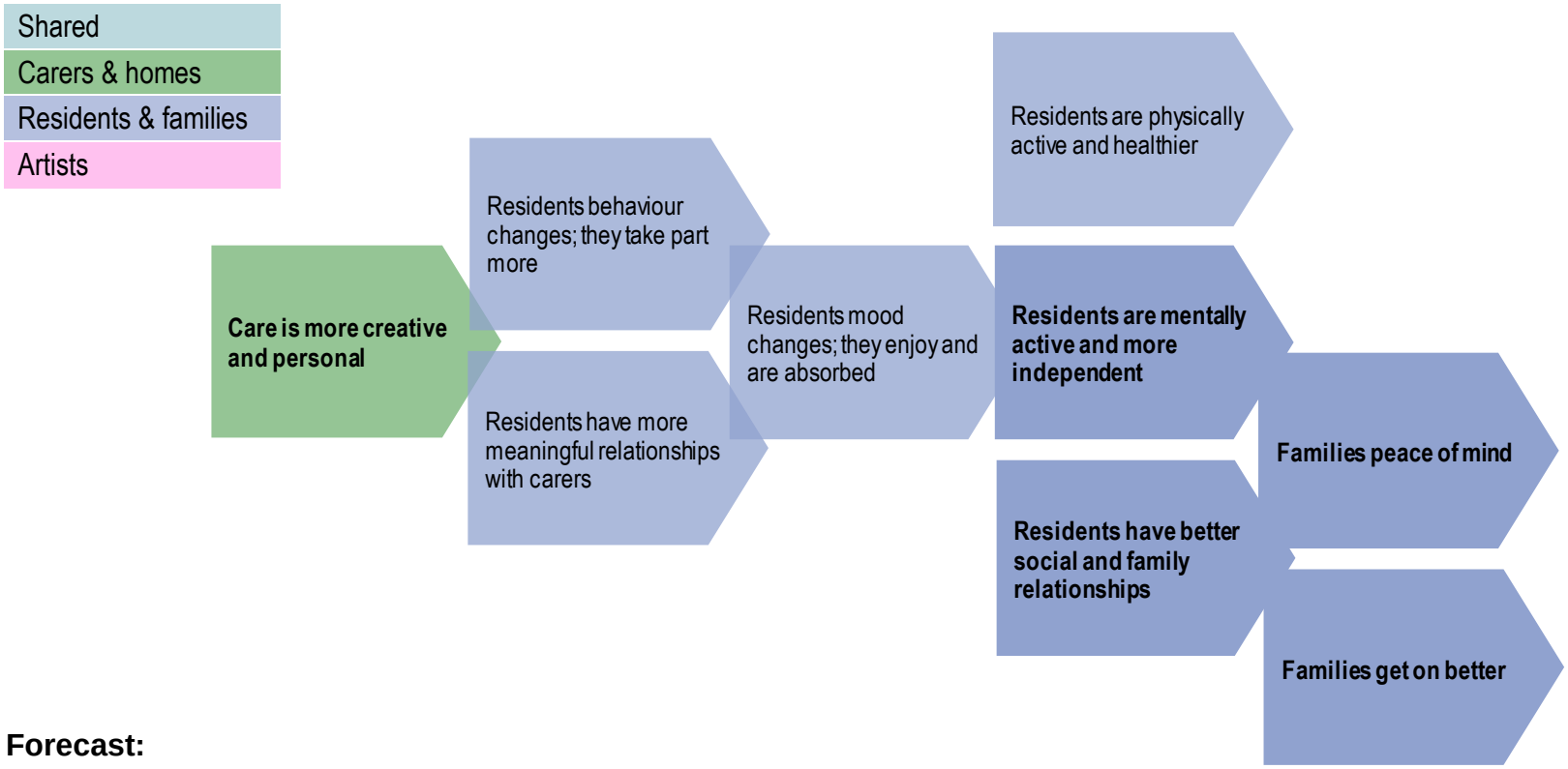
- Care is more creative and personal
- Workforce development and sustained practice
- Better long term care of residents visible to staff & families

- Artists re-think, re-value and improve this and other creative practice

Outcomes which could be further researched include:

- Physical benefits to residents
- Changes to demand for health and social care services

Chain of events for residents and families



Forecast:

Whole home change means care for all residents is more creative and personal

Better care affects 3 residents a little and 24 residents a lot, changing behaviour then mood, leading to more active independence

Five also improve relationships in the home and with families (cautiously claimed to avoid double counting)

Improved care gives half of these families peace of mind

Relationships for family members also improve

In the delivered programme, the introduction of more creativity into activities had some profound effects on a few residents, and affected almost all the residents in homes to some extent. This was true whether or not they were dementia homes. Independence and relationships remain important to both groups and whilst they might have different capabilities, they appreciated the same creative input. An approach that works for those most at risk of poor outcomes provides a good discipline for making creativity accessible to everyone. Individually, **residents become more mentally active and more independent.** Two approaches were used to test the changes; Dementia Care Mapping at activities and during everyday care, and the homes themselves monitored the level and type of contact asked for by residents. The initial effect on residents is becoming more involved. They become quite engrossed in new creative activities and prepared to try new things that they might not before. They have fun and enjoy themselves.

During an origami session, one resident was organising all the folded card and a carer commented this was the most contented and engrossed she had been seen.

By becoming more involved, residents become more mentally active. A care home manager described how unprompted

> ***" one resident - and the others all agreed - said she had noticed a difference in the activities and how much she had benefitted and enjoyed being taken out of her comfort zone"***

This sequence of involvement and improvement is part of a virtuous circle which impacts on the workforce (see below) and back again on residents. It aligns exactly with the Social Care Institute for Excellence's (SCIE) definition of excellence in social care[xxvi] which identifies 'spending time purposefully and enjoyably doing things that bring them pleasure and meaning' as one of four elements of excellence.

A small number of residents who usually made 10 to 20 calls through the night reduced this to around 3 calls after creative activities. This change from superficial contact to more fulfilling engagement indicates more independent residents, who are not seeking the reassurance of contact. At the same time most residents were observed eating well, seemed more settled and had fewer behavioural issues, as well as being more able or willing to do things for themselves. Some residents with dementia were noticeably more engaged; in some cases more able to speak up for themselves if things weren't right - as one manager said ***"it's the personality speaking not the dementia".*** Once the changes reach a tipping point much of the home was affected, with just a few residents continuing to be resistant to any changes.

There are clearly social impacts of being more mentally active and vice versa with **residents seeing improvements to their social and family life**. Relationships with carers, other residents and families or other visitors were all affected, though we exclude relationships with staff from our value analysis because of the risk of double counting. Integral to this is the public display of creativity:

In one care home this was beautifully demonstrated by some photo-collage work which was immediately placed in a

wooden frame, displaying the sociable side of the home as a conversation point for relatives, residents and carers.

However this has been found to be at odds with some care homes' approach, as one carer put it, ***"they want the home to look like a hotel for anyone visiting"***. It emphasises the need for whole home culture change.

There is a significant knock on effect on families of improved independence and relationships. Although the families' survey was unable to quantify outcomes, it provided useful narrative of what they valued in care. Choosing a care home is a huge responsibility for a family. Knowing their relatives are in genuine 'homes' where they can be independent and have social lives gives **families peace of mind.** Where homes are trusted, families favour them over public services to take the right care of family members. In the words of a manager ***"social services tend to be looking for either very sheltered housing to keep older people out of homes, or nursing care. Families see very sheltered housing as insufficient, and nursing care as 'oh my god'."*** Another manager describes how around 80% of older people assessed by social care services will be judged as needing nursing care, and as a consequence they ***"just go to bed"***. The tendency for public services to be over cautious in assessment is implied by the JRF workforce development report, where pilot projects found that their own assessments showed much less than the full nursing offer was required.

Releasing adult children from the caring role, and at the same time ensuring relatives are cared for not institutionalised, can be both a relief and restore the order of things. As one daughter says, ***"I got mum back"***. It is part of a virtuous circle of workforce development, better care and families' peace of mind.

Improved relationships are clearly two sided, with **families benefitting from getting on better** too. Most visitors care profoundly about their relatives or friends, ***"I love him more than anything".***

But for some the move into a care home can test relationships. Creative Caring can make the home a more enjoyable place for relatives too. Visitors were asked if things had changed since the home was trying to care more creatively. They reported improvements for residents, which had a knock-on effect on their own feelings towards the situation, and direct effects on their relationships too, in their own words:

> ***"She has been more independent and will go on trips without me".***

> ***"He seems very well cared for and that makes dealing with this a lot easier".***

> ***"We have been able to do things together more. Makes life more interesting".***

Although we'd initially asked homes to monitor health and medicine use, this information was not collected rigorously enough to affect the analysis, Dance or other physical arts can quite obviously help with fitness, but a review of the

research also shows that the 'absorption of the creative processes that are not obviously physically exerting can lead to an increase in the levels of general daily activity that older people undertake[xxvii].' At the same time, as well as the direct and obvious benefit of better relationships, the World Health Organisation has shown that social interaction is inversely related to the risk of falls. Knock-on effects on physical wellbeing could be explored in future programmes and valued for both residents and the health sector.

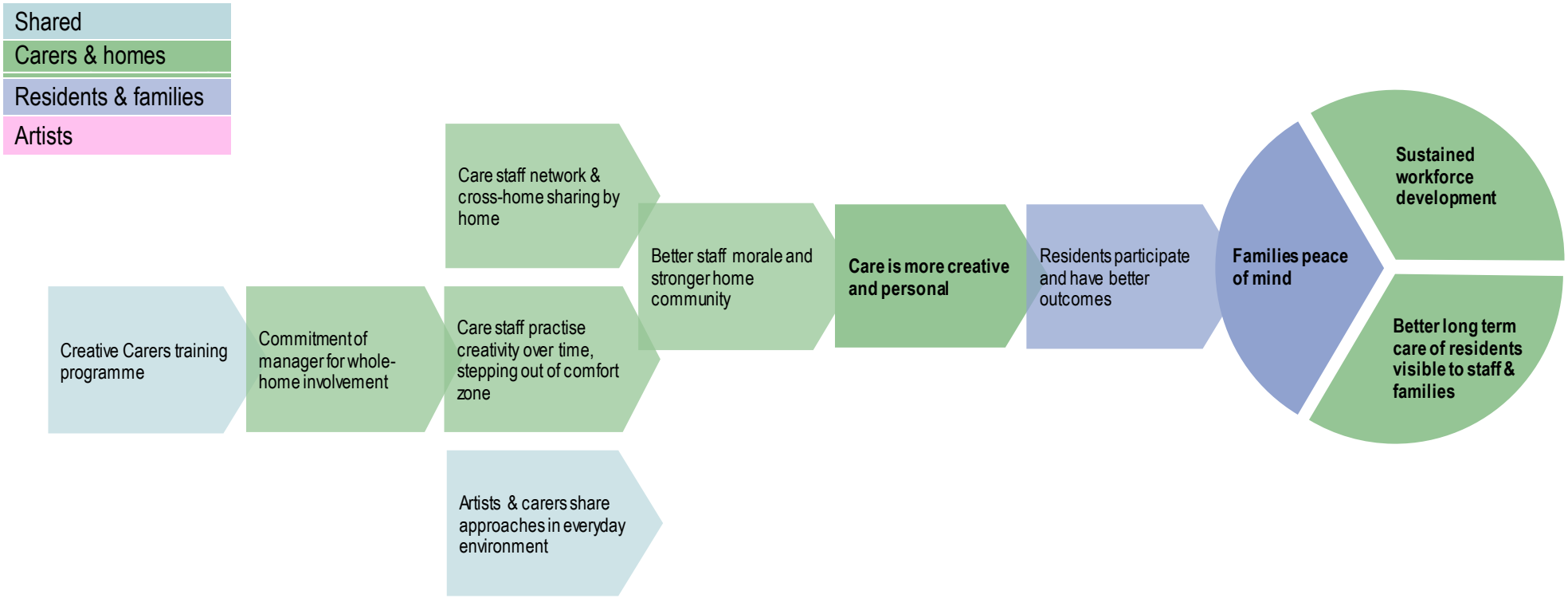
What the evidence says about older people's outcomes

These outcomes are in tune with what research shows older people value. JRF's *A Better Life*, cites personal relationships and relationships with carers as most important for social wellbeing, followed by self-determination, life continuity and pleasure which are related to being mentally active. Research into equality shows that the continuation of mental health was valued over physical health[xxviii].

Relationships are important to everyone, but especially valued by older people, as tested by Bowers et al in 2009 and Williamson in 2010. The Office of National Statistics research shows that those who agreed that local friendships and associations meant a lot to them increased from 64% of those aged 50 to 54 to over 80% of those aged 70 and over. About 82% of those who agreed that they belonged to their neighbourhood also reported that they were satisfied with their life compared with 53% of those who disagreed[xxix]. It's important therefore, that care homes replicate the benefits of friendship and neighbourhood.

It is worth noting though that for the state the resource impact of physical ill health is also significant, and though this analysis focuses on mental agility, further Creative Carers research should look at these benefits too. For example, "Happiness doesn't just make people happy—it also makes them healthier". John Weinman, Professor of Psychiatry at King's College London, monitored the stress levels of a group of volunteers and then inflicted small wounds on them. The wounds of the least stressed healed twice as fast as those of the most stressed. At Carnegie Mellon University in Pittsburgh, Sheldon Cohen infected people with cold and flu viruses. He found that happier types were less likely to catch the virus, and showed fewer symptoms of illness when they did. So although old people tend to be less healthy than younger ones, 'their cheerfulness may help counteract their crumbliness.'[xxx]

Chain of events for care staff and care homes



Forecast:

32 care staff trained over two days	Home or regional manager involved	Nine months support & 3 sessions from artist on-site Home organises own sharing	Most (accepting around 5 resistant staff) improve own and team morale	This impacts on 27 residents with resultant benefits to home	Improved care motivates workforce, creates whole home change and gives families peace of mind in a virtuous circle

Once most people in the home have been involved in Creative Caring, this can lead to a new atmosphere of mutual support and community amongst staff and between staff and residents. The knock-on impact on staff is both emotional and very practical. With residents more able to do things for themselves and less likely to seek mundane contact, **care is more creative and personal**. This benefits carers and care homes in at least two ways. Firstly it gives them more time to get to know residents, better bolstered by creativity as a tool to find a 'new point of contact, something to talk about, a different form of interaction'. [xxxi]

One carer described being given time out of her caring duties to help with activities as a result of Creative Carers. She said she felt more able to chat to residents because through the activities she knew more about them which gave her something to talk about.

Consequently, staff can better anticipate and head off problems. One manager described:

One gentleman, Ronald used to get very agitated because he wanted to be outside. Once he'd become distressed a member of staff needed to go out with him and spend hours walking up and down. This year, knowing the people as individuals, the staff are able to recognise the agitation as a trigger. They can take Ronald for a drive in the people carrier, which he loves and then he's happy to come back much sooner.

This approach was acknowledged by the JRF workforce development pilots, who found that after doing proper residents' assessments, the need for staff time was less than the full nursing time requirement, at between 58% and 65%.

Secondly, there is more staff time that can be spent on other developments such as training. With huge pressures on the care workforce for mandatory training and to increase health care skills this is very valuable to care homes. The situation creates a virtuous circle, with higher morale for staff leading to higher morale for residents and vice versa.

Alongside these better encounters carers own skills are developed, leading to a greater sense of empowerment and self-esteem and to them being more motivated and happy in their jobs. At whole-home level, this means **sustained workforce development**.

At the same time the **better long term care of residents becomes visible to staff and families** and demand is likely to increase. As a rule, care homes places are filled by reputation rather than advertising, which is usually spread through word of mouth. As such the visibility of good care is paramount. Creative Carers worked with some excellent homes with waiting lists rather than vacancies but nonetheless they place high value on this benefit. For care homes that are struggling, or for other reasons have vacancies, this is especially important.

These two outcomes are part of a virtuous circle of workforce development, better care and peace of mind.

What the research says about care home outcomes

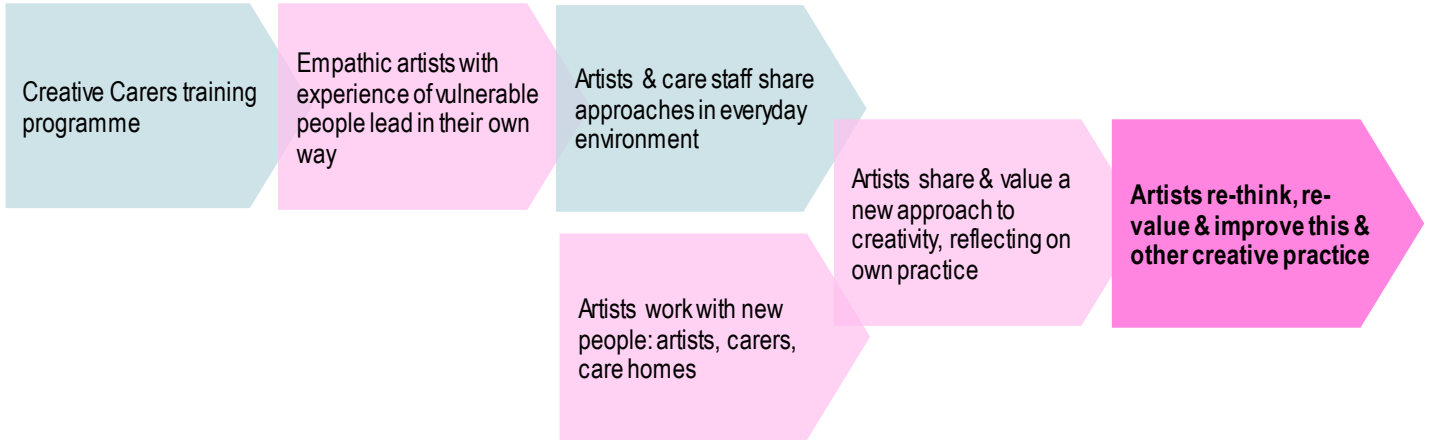
JRF's workforce report says carers need time to get to know the person and understand their life story if they are to develop good relationships and work respectfully. They also need time to understand how they should approach specific tasks if they are to help rather than hinder[xxxii]. Help the Aged pointed out in 2006 the benefits of better anticipating health problems, so they can be effectively headed off and health support can be used more effectively. Older people consulted for *A Better Life* talked about carers being over-stretched and not able to help with additional tasks, implying that their own care was constrained as a result. Contributions of time are considered as valuable as money.

Employers need to address how to achieve high quality integrated health and social care without staff's workload becoming overburdened. A knock-on effect in the workforce report is that in the pilot which did best in this area, increased workload was spread more evenly across NVQ2 and NVQ3 staff and staff had adopted a more team based approach to meet the fluctuating needs of residents.

A further finding of the workforce report was that homes thought that a reputation for quality would provide added commercial value including maintaining high bed occupancy.

Chain of events for artists

Shared
Carers & homes
Residents & families
Artists



Forecast:

New artist training/role for five artists	One consistent delivery artist in of five homes	Nine months support & 3 sessions from artist on-site	Artist own training and learning from homes	Leads to improved practice

Just as creativity improves care, so care improves creativity. The impact on the artists will be smaller than the impact on the carers and residents, but by re-thinking and re-valuing creativity in care homes, the arts sector can learn to put care at the heart of creativity, improving practice with older people and other participatory work, particularly with vulnerable people.

On the other hand Creative Carers is a very real example of the social benefit of the arts, with creativity translating directly into improved care. The feedback from residents and care staff shows they are well aware of the artistic excellence in the process they are learning.

The artists themselves derive satisfaction from re-awakening creativity in others, and their involvement with carers, residents and the other lead and delivery artists enables them to **re-think, re-value and improve this and other creative practice.**

The dynamic relationship of care and creativity, the new creative coaching role, and the introduction of a new creative diagnostic for homes are all new practice for the artists and an opportunity for development by Suffolk Artlink.

Challenges or negative outcomes

As with any change in approach, there is a period of discomfort for some individuals and some homes. Each home also described some residents and some staff who remained steadfastly resistant to the change. In SROI terms it is important to establish if these have negative value; that is if they detract from rather than merely limit the overall benefits.

As far as the staff go, when asked specifically, managers could see no negative effects from Creative Caring but appreciated that it would take time to embed. They talked about a hard core of carers who remained resistant to this (or any) new approach. However, the feeling was that the training allowed the home to reach a critical mass of different practice, so that whole home change resulted. These few resistant staff may not themselves offer 'more creative and personal caring', but they are insufficient to have negative effect or to affect home culture.

With its focus on personal care, the Creative Caring ethos has to accept that individuals must be free to choose and that personalities and preferences in the home are as varied as they are in the wider community. This means some residents remain resistant to either creativity, or building relationships or both. Again, we asked if these residents were worse off after Creative Carers. They could for example have felt more isolated in a changing home culture. However managers reported that these residents are the type of people who simply prefer to keep themselves to themselves tending to stay in their rooms, and that hadn't changed.

Testing different individual and social approaches would be a way to explore a larger impact

Evidence

How we know things have changed

Evidence that things had changed was collected through interviews, workshops, informal and formal observation, surveys, and behaviour monitoring. We had to cater for residents with dementia and Dementia Care Mapping proved very useful with other residents too. DCM was used to predict behaviour change, which was then confirmed by staff monitoring changing demands from residents. Surveys were less successful because of the lack of control over implementation, but interviews and observation throughout provided very rich material.

We collected evidence from the delivered model and estimates for the new model. To test our expectations we looked for indications of change in the opinion of stakeholders (subjective indicators) and in what happened (objective indicators). We also collated observations from artists and the evaluators throughout.

We asked two homes who weren't committed to other surveying at the time to complete mid and end point questionnaires with staff, visitors and residents (the last just completed by one home as the other was for dementia residents). These questionnaires were of limited value for two reasons. Firstly we had little control over implementation. Secondly, as a formative analysis the programme delivery and therefore Story of Change was developing as the project progressed. The questions asked at baseline were only part of what we needed to know at the end.

Residents

Residents have very wide-ranging abilities, with some homes catering entirely for people with dementia, and others who are very mentally able. The latter group were able to comment on their experience, but to learn about the former we relied on the observation of others.

Indicators that residents are being **more mentally active and independent** are: the quality of participation, Dementia Care Mapping behaviour (and mood) change and more fulfilling carer time being spent with residents. Initial indicators were that residents were participating either in activities or in conversations more, and in a more lively and engrossed way. Dementia Care Mapping tested this robustly allowing a percentage change to be established, through two sets of codes. Behaviour codes show what actually happened. We looked for increased 'creative or expressive' behaviour. Mood and Engagement values also showed the effect this had on residents, by looking for signs of happiness and pleasure or the opposite. The extent to which this influenced residents after activities and in the everyday was tested by carers monitoring the nature and number of calls on their time in the three shifts after a Creative Carer intervention. Staff were asked whether this had continued in the long-term. The DCM figures were used to estimate the volume of change for

the majority of residents, with carer observation quantifying the minority group who experienced a bigger change. The number of residents in each group was counted by managers.

Indicators that residents have **better social and family life** are: residents join in more and families visit more. To try and avoid double counting we were looking for explicit social behaviour; more joining in and more family visits as estimated by homes – this means the results for this outcome are probably under-claimed.

Families

Indicators of **families' peace of mind** are: good residents' outcomes, willingness to pay or to wait for a better service and comments or complaints to the home or CQC. We think the changes to residents' independence and mental activity also indicate that families will have improved peace of mind. However this is only relevant to those we are really engaged with their relatives so we quantify the result only for those who visit frequently. This outcome was established retrospectively so estimated here. In future analyses, homes should also monitor demand in the form of top up fees, waiting lists and so on, and also comments about the service received by them or the CQC.

Indicators for **families getting on better** are: more family visits. These figures were estimated by homes.

Care homes

Indicators that **care is more creative and personal** are: good residents' outcomes, changes to residents needs and calls on staff time. The evidence for residents becoming mentally active described above also show that care is more creative and personal.

Indicators of **sustained workforce development** are: improved team spirit, expansion of the Creative Caring approach and staff turnover or absence. In looking for wider workforce development and sustained practice, we held a workshop with two homes managers and activity co-ordinators, and interviewed three more managers (two home and one regional manager) to establish the range of staff involved and their feedback a year on, asking if sharing and the team approach had grown.

One example from a home illustrates several outcomes. With National Care Home Week falling this summer, care homes around the country are preparing for open days and events. Typically the home would have got the florist to make the home look beautiful. Post Creative Carers however, the role has been taken on by residents and care staff working together. They've used flowers that they've planted themselves - that have their names on - to create their own displays. This shows the creativity of both residents and staff, as well as their improved relationships and increased sense of personal ownership and community.

In looking for objective indicators, we expected this would lead to more demand from staff for other training and development, and less staff turnover. In fact, we found some homes might feel their workforce is complacent and turnover is not therefore a good indicator. Instead we suggest monitoring staff sickness for future delivery.

Indicators of **better care being visible to staff and families** are: whole home change to caring and more demand for places. Finally managers were clear that more visible creative care would make a difference to demand. We asked managers to judge whether there had been a difference to the whole home, but failed to collect information about subsequent demand so we forecast using the managers' view. This was partly because several participating homes already had long waiting lists and could be better tested in a home with vacancies.

Artists

Indicators for **artists improved their practice** are: artists report using the Creative Caring approach elsewhere. Artists were emailed a survey a year on asking if they had changed their practice as a result of Creative Carers, and if so the frequency (daily, weekly monthly).

Summary of indicators [xxxiii]

Outcome	Indicators & evidence collection
Residents are mentally active and more independent	Quality of residents' participation. % improvement shown by Dementia Care Mapping. % change to the nature of demands on carer time. Resident questionnaire.
Residents have better social and family relationships	Residents join in more, more family visits.
Families' peace of mind	Good residents' outcomes. Willingness to pay or wait for a service. Comments or complaints to CQC.
Families get on better	More family visits.
Everyday care time better spent	Good residents' outcomes. Changes to residents needs and calls on staff time.
Workforce development and sustained practice	Team spirit. Expansion of Creative Caring approach. Staff turnover or absence.
Better long term care of residents visible to staff & families	Whole-home caring changed. More demand for places.
Artists re-think, re-value & improve this & other creative practice	Use Creative Carer learning elsewhere.

What the research says about collecting evidence

The Arts and Dementia Pilot tested the Lodex wellbeing self-assessment with participants. They found it long and difficult to complete, which ironically for a wellbeing tool made the participants rather anxious. Although not so fully tested, they found the tool they devised and completed together with the participants was well received, "It was lovely, we just had a nice cup of tea"…. said one resident.

The Dementia Care Mapping (DCM) approach employed in this research has the benefit of not needing resident feedback. The team at the University of Bradford developed it to improve the quality of person-centred care. One mapper observes 5-8 people over some hours, with recording occurring every five minutes. It is used internationally in over 25 countries.

The University of Bradford team say that it helps to meet the policy context by:

- Providing detailed information about the lived experience of the person with dementia
- Reporting the quality of care received by people who may not be able to communicate with us
- Depicting the quality of staff interactions – which can indicate the general culture of care
- Highlighting periods of disengagement and unmet needs
- Recognising quality, positive person work

Forecast results

Both resident and home results from this round of delivery allow us to confidently predict future outcomes. DCM showed a change for most residents, with a minority making significantly fewer 'contact' calls and a few joining in more obviously with social activity. Fewer contact calls will release many hours of staff time for proper engagement and other developments. All the homes interviewed experienced whole-home change, even though the whole-home training had not yet been put in place.

Evidence from families was more qualitative than quantitative. We forecast significant impact on families, mostly through peace of mind, but are less certain of numbers here. Artists felt limited impact, because this programme focused on the demand rather than supply of Creative Carers, so our forecast for them is cautious but likely to improve in future.

There were challenges in collecting evidence which can be easily addressed in the new model.

The minority of residents who experienced a big change in **mental activity and independence** were monitored over three shifts after creative activity, through the night and into the next morning. **One example was Edith, who would typically ring for contact 20 times a night. Instead she made three calls, two for the toilet and one to check staff were going to get her up. Another home gave the example of Phyllis, who didn't go to the toilet at all during the activity – again a significant improvement.** Managers estimate that there might be 3 residents experiencing this kind of effect with 10 contact calls a day being typical from each.

More generally though, the programme was estimated to have affected around three-quarters of residents. DCM was used to estimate the extent of the change. We compared a Creative Caring activity with everyday care, and we compared activities over time and in one home everyday care over time.

All of the comparisons showed a marked improvement in expressive behaviour. The activity creates much more expressive behaviour than everyday care with resident behaviour 18%, 27% and 37% more expressive[10] with the activity. In one home, there was also a significant improvement in awakeness, of 21% more time spent awake. Where comparisons were made over time, all showed an improvement too, of 7%, 12% and 16%, even in the short four month period monitored. The smallest of these showed changes to everyday care, indicating that Creative Caring was having an effect.

In our conservative forecast of changes to both resident and family **relationships**, managers judged on average around 5 residents and families experiencing improvements. We quantified that using the DCM figures.

Similarly, we judge that the **peace of mind** outcome is as a consequence of residents being more mentally active and independent. However it can only be applied to those families

[10] DCM term to encompass more engaged, creative and expressive behaviour

who are engaged, considered (conservatively) to be around 50% who visit frequently.

The results for **care becoming more creative and personal** are a direct consequence of the residents' results, with 10 minutes per contact call estimated by a manager, and a typical high user making contact 10 calls a day, with 85% of these saved. The whole-home results were estimated by managers too.

Managers all reported whole-home change: ***"One new initiative is a 'stop for coffee' time when EVERYONE in the home stops for a cup of coffee with a resident they haven't met before - this has prompted conversations between people who would not normally engage and also meant that staff get to know their residents much better."***

However there would typically be three to five staff remaining resistant to change so the whole-home change is reduced slightly for the **sustained workforce development** outcome.

The second whole-home outcome, **visibility of better care**, depends on a critical mass rather than all staff being on board, and so is counted in full.

Finally all of the artists who responded noted improvements to their **creative practice**.

Summary of results

Outcome	Forecast[xxxiv]
Residents are mentally active and more independent	24 residents (of 32) see a 21% improvement in mental activity/ independence. 3 residents see an 85% improvement.
Residents have better social and family relationships	5 residents have improved social and family relationships judged to be a 21% improvement in line with above.
Families peace of mind	Half the 27 families of residents more mentally activity improve peace of mind
Families get on better	5 visitors experience improved relationships judged to be a 21% improvement in line with above.
Everyday care time better spent	Resident's independence releases 10 minutes of staff time with each avoided call. At 21% or 85% improvement this is 20 minutes or 1hr 25 minutes per resident for 24 or 3 people.
Workforce development and sustained practice	Bar a small group of resistant staff (5 out of 27) there is a whole-home change.
Better care visible to staff & families	Whole-home change.
Artists improve creative practice	All artists saw changes to their practice.

Challenges

This was a challenging analysis for three reasons. Firstly many of the residents were unable to share because of their dementia and secondly because of the stages of removal of some of the stakeholders. The training programme itself was working at a step removed from the care homes, having been agreed with area managers not care homes themselves. Analysis was commissioned by Suffolk Artlink for work going on in care homes, who in turn have families as their customers. Consequently the residents and families were in effect two or three steps removed from the evaluators. The same is true of the training programme itself, which few residents or families realised had taken place. We are not alone with these challenges. The JRF workforce pilots had the same problem with 'few residents or relatives aware of the particular approach being used'.

Thirdly, because the model was changing as the programme progressed, the data needs changed too.

However the evidence collection is a very tangible way of motivating staff and homes to participate and we recommend it becomes part of ongoing delivery. In further delivery Creative Carers should continue to use the DCM method and staff monitoring of contact time. Although we attempted to monitor medicine and health needs this was unsuccessful and could usefully be tested too, with other more objective indicators. Programmes should include better baseline collection with staff as part of the diagnostic. We make these recommendations below.

Impact

Next we tested what Creative Carers could take credit for. In an enclosed environment like a care home, change can be put down to what happens within that environment. In this instance other training and development was estimated to account for over two-thirds of the impact on the home itself, whilst for the residents there is an additional small effect from going out too. A typical resident care home stay is two years, and we expect residents to benefit through that time. Home changes will be superceded by other factors sooner though, limiting what Creative Carers can claim.

What was due to Creative Carers

Deadweight, attribution and displacement[xxxv]

There are plenty of other things going on in the homes that may also be contributing to the changes we describe. SROI analysis should account for what Creative Carers cannot take credit for – what would have happened anyway (deadweight) and what something or someone else was responsible for (attribution). Several of our homes were also involved in Eden Alternative Training and Ladder to the Moon training during the period, as well as the mandatory training of various kinds that develops the workforce.

Because the care home is an enclosed environment to which most outcomes directly refer, the only relevant issue is attribution - no changes would have happened anyway in the home environment, without them being implemented by the care home in the form of training or organisational development. There is no clear way to extricate the impact of Creative Carers from these other elements, so we asked two managers to estimate the affect, which ranged from 40% to 25%. To test this figure, we compared the time spent on training for Creative Carers to the time spent on induction and mandatory training for a new member of staff. Creative Carers takes around a quarter of the time of induction. We also looked at the staff survey to see what they reported in the question about whole home impact. 28% reported that all staff in the home were involved. Whilst none of these methods of attribution is perfect, the four figures of 40%, 25%, 25% and 28% are sufficiently close for us to feel fairly confident in attributing 28% of the change during the period to Creative Carers.

For residents and families, similarly the nature of the environment limits other effects. In fact, many going into care homes experience worsening outcomes and a negative deadweight would not be implausible. Other influences on residents are limited to the time they spend out of the home, visiting with family or going to social clubs for example, but on top of what has already been attributed to other activity by the home.

Conversely artists experienced no other Continuing Professional Development (CPD) during the time, but as creative people who are always developing, what would have happened anyway

through other work and contacts, they judged may have accounted for half the effect.

Finally SROI must account for 'displacement' – any issue that was transferred, or benefit that was taken from another place. There are clearly no negative knock-on effects of residents' outcomes in this analysis, and as workforce and business improvements the same is true of the home. Similarly, the only thing that might be 'displaced' in artists' experience is less effective practice.

An area for more long term research however, is the displacement impact on the whole system we touched on above.

If there is a general improvement to residential care to the point where people are living longer and demand for places is increasing, costs to the NHS, families and local authorities could change. As one of our family interviewees responded:

> ***"Mum came into the home with a need to be cared for physically and mentally as directed by a social worker at [another organisation] following 4 months in NHS care and a pessimistic prognosis. She has since regained her weight and seems as well as can be!"***

How long did it last?

Duration

The average care home stay is two years. Bearing in mind Creative Carers is at least a nine month programme, it seems likely that the effects would last for another year, so we estimate the duration of resident and family outcomes to be two years with the drop off 50% in each year. The effect on more creative and personal care would be equivalent.

Recent years have seen a shortening of the average time residents spend in a home, as people put off for as long as possible moving from their own home. And there is clearly a limit to how long resident outcomes can last due to life expectancy. But changes of the type we describe above, and more of a move towards residents looking after themselves could have a longer term impact on the home. The length of stay may increase, either through earlier entry or longer life. We test a longer duration for outcomes in the sensitivity analysis below.

Anecdotal reports from homes who have participated in previous years indicate that changes to the home might last a while. However we have estimated that the whole home benefits should be valued for a year, as other training or policy changes may well supercede the Creative Carer effect – in fact they are encouraged to in the notion of embedding. Similarly, artists' lives are rich and busy, so other factors are likely to take over soon.

Social Return On Investment

To quantify the benefits and compare them with the investments, we used real and proxy values from our and others' research. Value to the home is tangible and can be represented by business spend with the most important being the use of staff time. Values for residents and families are high but more intangible. These are emotive issues for vulnerable people and caring is generally under-valued.

Investments by the home are the cost of training and staff time. For families the investment is unseen, but is the proportion of their fee which the home spends on staff and activities.

Together and separately homes and families see a good return on their investment. The case for artists needs developing.

The value of the change

Towards the end of the project we ran a valuation workshop for the two care homes who had been involved in ongoing research with the managers and activity co-ordinators attending as well as the artists and Suffolk Artlink. We used an adaptation of the value game[xxxvi] to review the outcomes and prioritise value. We then tested these in interviews with three further managers. Having identified various things that gave the home tangible and intangible value, we then ordered these and finally applied proxy values to them in discussion with two managers. As well as giving us values, this meant we reconsidered some of our outcomes.

Homes estimated resident values and we compared these against research. We asked visitors in surveys how important outcomes were to residents, but not for specific values as we were too distant from them to explain this concept. They gave very high value to mental independence, physical health and relationships but did not differentiate, so we looked for more nuanced valuation in research.

We valued being **mentally active and more independent** as what someone might pay to stay in their own home through home adaptations, a home help and regular taxis, recognising that fending for oneself keeps people mentally alert. Experience of people becoming 'institutionalised' when they move into a care home is commonplace. Although this is made up of physical support, it is the amount that people are prepared to spend to maintain independence that is important. The value we use is £8,390. We test other valuations below.

Research shows that older people value **relationships** highest of all (see research below) and more general research into the value of better relationships with friends and relatives shows this to be £15,500 a year.

Interestingly, both the personal and relationship outcome values for families are very similar to those for residents, even thought they were derived in quite different ways. This lends extra credibility to the proxy values.

The value we place on **families' peace of mind** is derived from what people are prepared to pay to 'top up' social service fees to buy themselves a better quality home. At an average of £163 a week, this is £8,450 a year. The value for **family relationships** is the average earnings a carer might give up to look after a relative at home at £15,260.

The values for residents and families are very high and may look disproportionate in the Impact Model, so we test them below. However, both national and our own research show that the individual and family experience of older people in care is so important, ***"I love him more than anything"*** and in many cases traumatic, that we believe they are valid.

The values for the homes are very tangible. **More creative and personal care** is valued at a care staff wage of £7.20, recognising that this time has been reclaimed for more valuable work. **Sustained workforce development** equated to what one home spends on a bonus scheme, £1,400, although one home indicated much higher value, equivalent to what they spend developing staff morale through meals out, and another home higher still at a wage hike for all. We test these two values too. The value of **more visibly good care** is equivalent to a marketing spend at around £3,000. Most home reputation is established through word of mouth, but an under-performing home might generate a marketing spend.

Finally, the value of **artists' improved practice** is equated to a typical workshop and is out of proportion with the rest. In SROI terms artists could be judged immaterial, because although they are relevant they are not significant in the numeric model. However there is good reason why we include them here. The fundamental purpose of Suffolk Artlink is to develop and offer opportunities to artists. At this phase in Creative Carers' development the focus happens to be on the demand side of the service, getting the delivery model right and establishing the case to the homes for investing. More frequently and certainly in the next round of delivery, the focus will be equally on the supply side, developing the quality of the artists work and their personal and professional growth. As we anticipate this analysis being used again, it's important the place of artists is held so future developments can be included.

We tested both home and artist values with them directly.

Summary of values[xxxvii]

Outcome	Values
Residents are mentally active and more independent	What someone might spend to stay in their own home: home adaptations, home help and taxis - £8,390
Residents have better social and family relationships	Older people value relationships highest of all. Above plus 10% - £9,229
Families' peace of mind	Willingness to pay top up fees of £163 a week, or £8,450 a year
Families get on better	Earnings someone might give up to look after their parent at home - £15,260
Everyday care time better spent	Hourly rate - £7.20
Workforce development and sustained practice	Whole-home yearly bonus scheme - £1,400
Better long term care of residents visible to staff & families	One off marketing spend on an under-performing home - £3,000
Artists re-think, re-value & improve this & other creative practice	Typical workshop cost - £300

Having established the numbers experiencing change, the amount of change and the individual value that they might apply to that change, a simple multiplication gives the total value. We also take off what Creative Carers can't take credit for. Because some of the outcomes last for a couple of years, we show a return in year one and year two.

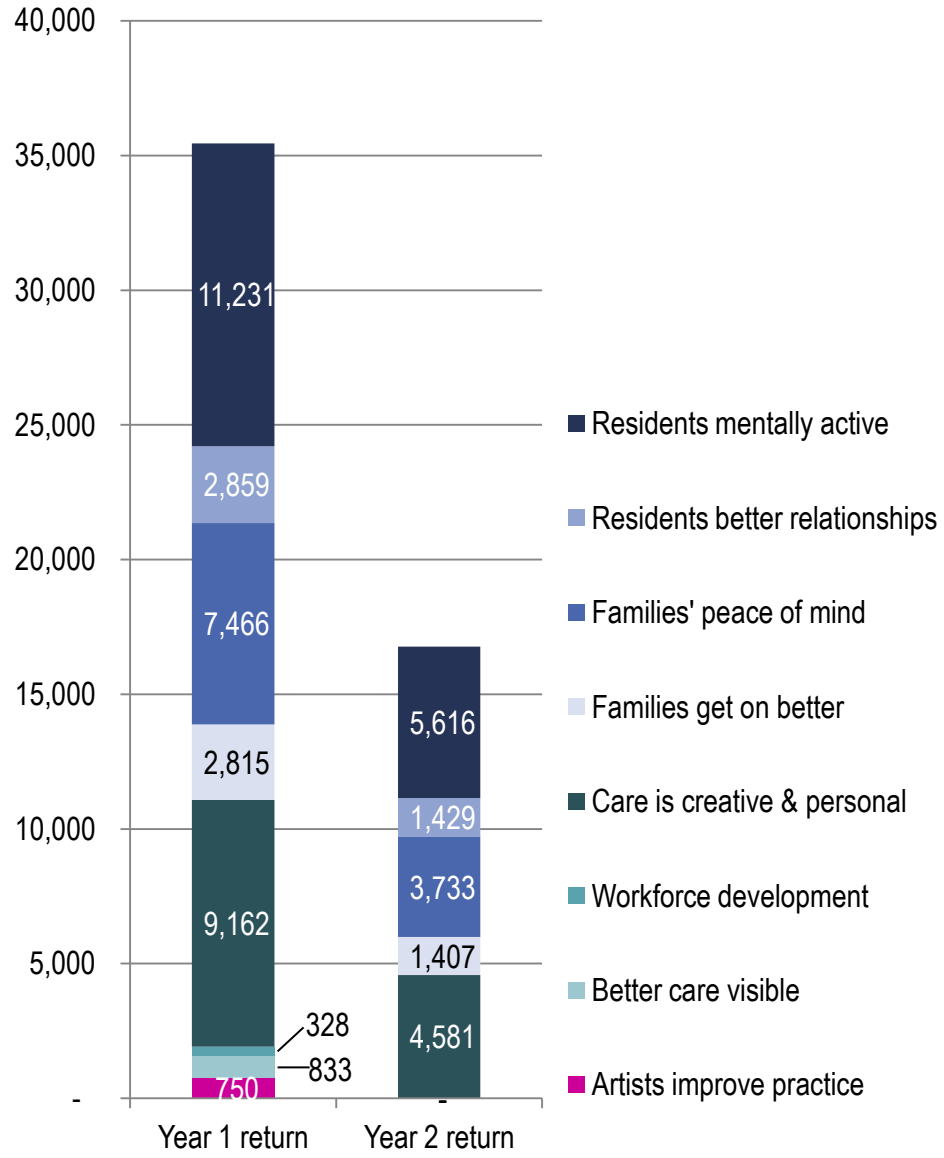
The biggest benefit is for residents being mentally active and independent at £16,847 over two years, because there is quite a large change and a high value. Better relationships have high value, but for fear of double counting with the first outcome we estimate a small number – only those engaging more with social activities – in total worth £4,288.

Families value peace of mind high, and many benefit, so the value is £11,199. Like residents, they value relationships even higher, but again with a conservative number affected - the total value is £4,222.

For care homes the biggest benefit, (which also lasts two years) is the effects of more creative and personal care. With many instances every day for many residents, over the two years this amounts to £13,742. Workforce development and better visible care is valued for just a year before it's superceded by other projects or training, at £328 and £833 respectively.

Artists' improved practice is also quickly superceded, and with only five artists and a small value compared with everything else that's on offer, this amounts to £750 a year.

Figure 4 Total value from Creative Carers



What the research says about valuing outcomes

The JRF workforce research identifies that 'just as older people will invest to avoid moving into a care home, once they have made this new home they are similarly resistant to being moved again, for example into nursing care'. Both demonstrate a value that older people place on each increment in their decreased independent control.

A Better Life shows those with high support needs value outcomes in this order:

- personal relationships, good relationships with carers, social interaction
- making a contribution, cultural activities, self-determination, continuity and adjusting to change
- humour and pleasure
- sense of self, mental health,
- safety and security, good environment,
- physical health, physical activities, getting out and about

Quantified evidence of value of older people's outcomes is limited, but it is worth noting that whilst it might not be immediately obvious, our residents' outcomes can be considered for value against the nature of falls for older people. A World Health Organisation (WHO) report states that social interaction is inversely related to the risk of falls, and we also know that decline of physical and cognitive capacities contribute. 40% of those living in long term care experience recurrent falls[xxxviii], which as well as being a major cause of injury and death, account for more than half hospital admissions in over 70s and cost the country £4.6m[xxxix]

Further research is currently underway to improve the QALY measure (Quality Adjusted Life Years) that the NHS uses to see if the value of an intervention exceeds the cost. This research, by Fujiwara and Dolan will measure the mental as well as physical wellbeing of people.

The value of the investment

To see if these returns provide value for money, we compare them with the value of the investment[xl].

For homes, there is not only the training cost to consider, but also staff cover for all staff to attend for two days, and the time of the home manager. This is calculated at six hours training for 32 staff at £7/hour, plus 30 hours of a manager's time over nine months at £19/hour totalling £2,027. The training itself will cost £2,786 which reflects the investment over seven years by Suffolk Artlink and the use of experienced artists to create a quality training programme. In total, the investment for the home is therefore £4,813. The value of the return identified above gives them a return of 3 on their investment.

For residents and families, the investment is hidden within the fees they pay for the care home place. Though there is no additional cost to residents of Creative Carers - the costs of the improvements brought about by Creative Carers are not (yet) passed on to the residents – we clearly need to recognise the significant financial investments families make for residential care. We have therefore included in the analysis the proportion of the care home fee that is spent on staffing and activities. The average spend by a home on activities per resident is £68 and care homes advise that staffing is about 65% of home costs. This amounts to £448 per family per week, multiplied by the residents benefitting. This total investment of £12,099 also gives them a return of 3 on their investment. Of course better quality care homes charge more, so in the longer term the investment of families may become more obvious.

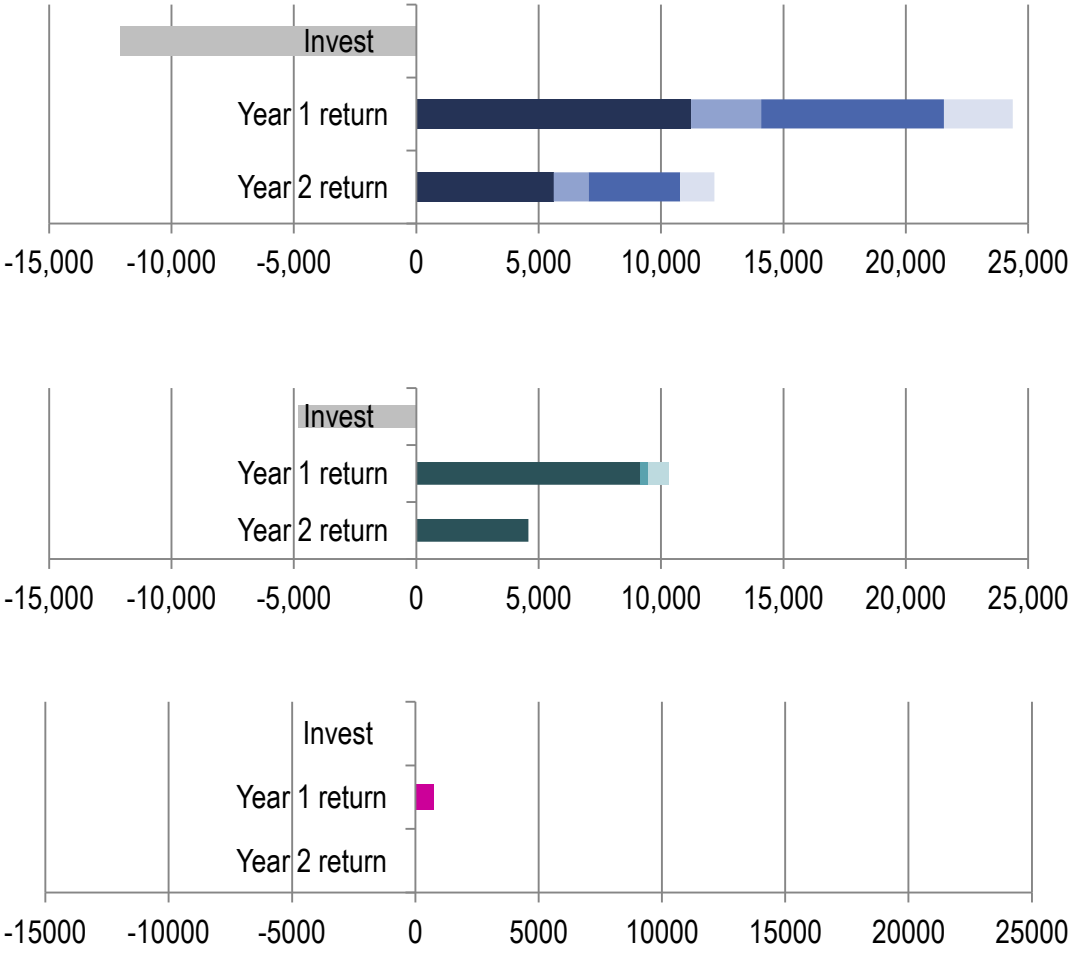
For artists, the investment of time is paid back in wages, so there is no investment value included and a small return of £750.

Quantifying these investments shows the benefit of using an analysis that captures social as well as financial costs and impact. It highlights the nature of the choices that the two main stakeholders have - families and care homes - in investing in Creative Carers. The decision to invest is made by the care home so *they* need to see a direct business benefit. But they are in effect, also making an investment decision for a family because except in an emergency, families are highly unlikely to move relatives. The families are highly dependent on the care homes, and the analysis could usefully be used to ensure the responsibility is fully appreciated.

Because returns next year are of slightly lower value to people now, year two returns are discounted by 3.5% in line with HM Treasury guidance.

Figure 5 Investment and return

Total investment	**16,912**
Total return	**49,896**
Return on investment	**3 to 1**
Families & residents investment	-12,099
Residents	
Residents mentally active	16,847
Residents better relationships	4,288
Families	
Families peace of mind	11,199
Families get on better	4,222
Care homes	
Investment	-4,813
Care is creative and personal	13,742
Workforce development	328
Better visible care	833
Artists	
Investment	0
Artists improve practice	750



Impact Model

Story of change		Evidence					Establishing impact					Calculating SROI in year 1			Establishing long term impact		SROI long term	Outcome total	Stake-holder total
The people who matter	The difference CC makes	How we know things have changed					Less what would have happened anyway	Less what someone else did	Less displacement	% CC can't claim	Change due to Creative Carers	Value of investment	Proxy value of change per year	Value of change yr: 1	How long change lasts	Drop off/ yr	Value of change yr: 2		
		Indicators	Results Number		Amount														
Residents	Residents are mentally active, and more independ-ent	Quality of participation. DCM of behaviour change. Carers' time better spent.	Majority whose everyday care is affected	24	% change using DCM	21%	Most expect decline through loss of independence and reduced relationships 0%	Residents' formal and informal contact outside the care home on top of attribution identified by care home below 82%	Outcomes have no negative effect 0%	82%	What CC can't claim taken off amount of change	Part of fee spent on activities and staffing 12,099	Cost to live at own home: house adaptations, home help, taxis 8,390	7,428 / 3,803 / 11,231	Average home stay for residents 2 50%		5,616	16,847	21,135
			Minority whose everyday care is affected	3	Change in unecessary calls	85%	4% / 15%												
	Residents have better social and family relation-ships	Residents join in more. More family visits	Social experience affected	5	% change using DCM	21%	4%						Income needed to compensate for less contact with relatives 15,500	2,859			1,429	4,288	
Families	Families' peace of mind	Residents' outcomes. Top up fees paid. Waiting lists. Comments/ complaints.	Engaged family (fequent visits) of majority	16	Reflects residents' mentally active outcome	21%	4%						Willingness to top up LA fees (£163/week) 8,450	4,938 / 2,528.24 / 7,466			3,733	11,199	15,421
			Engaged family (frequent visits) of minority	2		85%	15%												
	Families get on better	More family visits	Visitors coming more	5	% change using DCM	21%	4%						Value of unpaid care provided in UK per carer 15,260	2,815			1,407	4,222	
Care homes & groups																			
	Care is more creative and personal	Residents needs and calls on staff time change	Majority whose everyday care is affected	24	Hours turned to better use per resident year (20 & 85 mins per day)	126	Closed environment so accounted for in attribution 0%	Other CPD and organisation development. Average of estimates by care home managers 72%	All workforce and business improvement so no displacement affect 0%	72%	What CC can't claim taken off amount of change	Home group fee for one home 2,786	Staff hourly rate 7.2	6,059 / 3,103 / 9,162	Mirrors residents 2 50%		4,581	13,742	14,904
			Minority whose everyday care is affected	3		517	35 / 144												
	Sustianed workforce develop-ment	Team spirit. CC grows. Staff turnover or absence	Mgr sees almost whole-home change (typically up to 5 staff resistant)			0.8	0.2					Staff time to train. Manager time to support programm 2,027	Workforce motivation: cost of bonus scheme 1,400	328	One off improve-ment likely to be super-ceded by other projects 1 100%		-	328	
	Better long term care of residents visible to staff & families	Whole-home caring changed. More demand for places.	Mgr agrees impact enough to create whole-home change			1	0.3						Marketing spend on under-performing home 3,000	833			-	833	
Artists																			
	Artists re-think, re-value & improve this & other creative practice	Use CC learning elsewhere	Artists	5			As experimental people work generally evolves 50%	No other CPD in period 0%	Only displaces less effective methods 0%	50%	Full outcome equivalents 2.5	Time to train and deliver offset by earnings so neither -	Typical days workshop cost 300	750	Superced ed by other factors 1 100%		-	750	750
Total												16,912		35,444			16,766	52,210	-
Present values												16,912		34,245			15,651	49,896	
Ratio																		1 to	3.0

Recommendations

Overall these values create a return on £16,912 of investment of £52,210 (£49,896 at present values). This is a return of 3 to 1, though tests show the range is likely to be between 3 and 4.

Having created the SROI Impact Model, we tested the business model through our What if? analyses to help highlight what really matters. Some small values remain in the model because even though they aren't significant, they are very relevant to the delivery

What if? analysis

Once the Impact Model is complete the most useful part of analysis can take place. We test the assumptions we made and feedback people gave about results by trying different figures in the model. We also test what different delivery approaches might look like, for example if three instead of one care home participated. And finally we test the values we placed on the outcomes.

Various tests, including a negative deadweight reflecting many residents poor care home experience, lend plausibility to our analysis. They show that the return on investment is somewhere between 3 and 4 (if we were to include bigger relationship results) or 3 and 5 (if we were to estimate results using DCM mood scores, not behaviour scores), or even up to 10 if we remove the families investment (as it is a sunk cost). Most of the tests returned a ratio of between 3 to 1 and 4 to 1.

In this report, individual stakeholder returns are more useful analyses than the overall return because they are operating in quite different market contexts. It is the care home alone that makes the choice to invest. Whilst care homes are restricted by rigorous inspection, they are operating in a responsive labour market so their business decisions should focus on the workforce. At the same time families' choices are limited as they won't readily move relatives. So the home needs to take responsibility for the families' investment too.

To break even homes need only make a difference to the minority of residents who are demanding in terms of contact time. This may mean that the three care home model can be highly effective in creating business benefits for homes, as well as the more expensive one care home model. But with a responsibility for social benefits for families as well, we recommend that they aim to make a difference to as many residents as possible.

The Impact Model below shows the areas we are testing.

Impact Model – what if? analysis

Story of change		Evidence				Establishing impact					Calculating SROI in year 1			Establishing long term impact		SROI long term	Outcome total	Stake-holder total
The people who matter	The difference CC makes	How we know things have changed					Less what someone else did	Less displacement	% CC can't claim	Change due to Creative Carers	Value of investment	Proxy value of change per year	Value of change yr: 1	How long change lasts	Drop off/ yr	Value of change yr: 2		
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										4%		Cost to live at own home: house adaptations, home help, taxis	8,390	7,428				
										15%				3,803				
														11,231		5,616	16,847	21,135
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			Engaged family (frequent visits) of minority	2		85%								7,466							15,421
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										144				3,103				
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	Better long term care of residents visible to staff & families	Whole-home caring changed. More demand for places.	Mgr agrees impact enough to create whole-home change			1												
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Total													16,912		35,444				16,766	52,210	-
Present values													16,912		34,245				15,651	49,896	
Ratio																				1 to	3.0

Test number of residents effected and strength of affect (affects residents and care home outcomes)

Test use of behaviour codes from DCM or mood codes from DCM

Test a 'negative' deadweight as residents outcomes typically worsen

Test a higher relationship score, including with carers

Test a zero investment from the family

Test value of peace of mind

Test value of independence. Lowest value used in Impact Model

Risk of double counting by valuing social and mentally active outcomes. Test removing social

Test duration of average home stay

This is estimate for one whole home approach. Test an investment for three care homes.

Test different values from 3 different care homes, based on pay/training, or meals

Test different values for visible improvements based on marketing or increased demand

Testing results

- Test the number of residents affected and the strength of the effect (affects residents and care home outcomes)

  Halving the majority number of residents affected reduces the return on the mentally active outcome from £17K to £11K, and the return on families' peace of mind from £11K to £7.5K. Overall, this means that grouped together (because their investment is shared) residents and families' return goes from £36.5K to £27. However, because it also reduces the resident and family investment from £12K to £7 (a proportionately bigger reduction, as we are still expecting the other outcomes to provide a return), the return on investment *ratio* goes up to 4.1.

  Testing this result also reduces the return to the home from more creative and personal care from £14K to £9K. The return ratio for the home on a pound invested goes from 3 to 2.2, still a considerable return. In fact, the home will more than break even on its investment (including accounting for staff time), if it only achieves this outcome for the minority of residents (3) over the two years, which we address in our recommendations.

  Overall, halving the majority number of residents affected reduces the return from £50K to £40K. Removing this result altogether, and only accounting for the 3 with significant impact reduces the return to £23K, roughly half. But the investment reduces to a third, so that the ratio in fact, increases.

  This highlights the need to analyse stakeholders separately. It shows that from the homes' point of view, targeting certain residents would be highly productive and working with a few will create the greatest benefit. But this clearly reduces the number of families who benefit.

  This leads us to test the investment by the family in the values section below, and to reiterate the responsibility that the home has to consider family as well as business benefits.

- Test the use of behaviour codes or mood codes from DCM

  We've used the behaviour codes from DCM to forecast the change. If we instead used the Mood and Engagement scores, which doubles the amount of change and may represent a more long-term change, the return jumps enormously from £50K to £85K, with the ratio increasing to 5 to 1. We therefore estimate the return to be something between 3 and 5 but use the lower figure so as not to risk over-claiming.

- Test a higher relationship score, including relationships with carers

  If the relationship score is measured including the improved carer relationships, with 27 residents instead of 5 seeing an improvement, this value multiplies by five, increasing the return to £68K and the ratio to 4.

- However there is a risk of double counting by valuing social and mentally active outcomes. Test removing the social outcomes.

  If instead we take out the social outcome altogether, the return only drops to £46K with a return of 2.7 because we have been cautious in our estimates. We therefore estimate the return to be something between 3 and 2.7 and 4.

  Regarding both these tests above, further research into the relationship between personal and social outcomes is recommended.

- Test a 'negative' deadweight as residents outcomes typically worsen

  We have given high attribution rates to other training programmes going on in the home. This means returns for residents are much reduced. Yet many care home experiences are extremely poor for residents, and see life outcomes tailing off very fast. If we show this as a negative deadweight – that is what would have happened anyway is a worsening situation – even a -10% deadweight makes a substantial difference of £20K to the overall value making a return of 4.1. This gives plausibility to our analysis, and means if we are comparing our residents experience to a poor care home experience, we see a very significant benefit.

- Test a longer duration

  We show a maximum duration of 2 years for any outcome, as that is the average care home stay. However, if there was a significant whole system improvement, so that residents were more willing to enter homes younger, and they even lived longer, the duration of most outcomes would increase with the return going up to £57.5 and the ratio up to 3.5 to 1. However with the objective of Creative Caring becoming embedded, the returns would diminish fairly quickly as the impact of the training drops off. Five years of impact would only see in the region of a 3.7 return.

Testing delivery

- Test the investment.

  The Impact Model shows one whole-home delivery. The price for three care homes to be trained together – allowing 8 trainees to participate – is £1,500 with staffing costs making the total around £2K. The home could get almost the same rate of return, that is 2.9, if it invested at this level and just made a difference to the 3 high cost residents making many contact calls. This means the diagnostic could help managers think about focusing on certain staff and certain residents to make a big difference.

  Stripping out all but the outcomes dependent on this result - that is just measuring a) 3 residents more mentally active, b) 3 families peace of mind and c) 3 instances where care is more creative and personal - brings the overall return right down to £14K. However, it presents a higher ratio of 4.2 to 1 with the decrease in investment.

Along with other tests above, this shows that the most efficient area of focus is on these highly dependent residents.

Testing values

- Test a zero investment from the family

  The investment by families is by far the biggest, because they are paying substantial fees. Whilst in the long term, visibly improved care may push up fees and therefore families' costs, within this analysis this investment is committed by residents and families, regardless of the Creative Carer improvements. It is reasonable then, to remove the investment altogether from the analysis, so that the ratio goes up to over 10 to 1.

  This demonstrates the very different situations of the stakeholders in this analysis and explains why individual stakeholder returns are more valuable analyses than the overall return. Families are buying services from a market where high personal costs mean they are unlikely to 'shop around' – choice is often limited by what's available when a crisis occurs, and once residents are in a home, only extreme circumstances would prompt a move.

- Test different values of mentally active independence.

  Other values for being mentally active and more independent were cited as:

  - the difference between domiciliary and residential care costs at around £11K
  - earnings foregone by a family to look after a parent to home (the same value as for families below, but applied to a different stakeholder) at £15K
  - the cost of sheltered housing staff and care at £16K

  Testing the highest of these values raises the return to £65K and the ratio to almost 1:4. This value could usefully be further researched.

- Test different values of workforce development.

  Homes valued this in quite different ways, ranging from £13K to £1.4K. Using the higher value increases the home's return from £15K to £17K. It is not significant to either their return, or the overall return. However as an important part of the chain of events which leads to families' peace of mind we include it in the analysis.

- Test different values for visible better care.

  One way of valuing this might be through vacancy savings. With the value applied equivalent to saving one empty bed for half a year at £24K, the extra benefit is £6K to the home and the ratio becomes 4.3 to 1 (3.3 to 1 overall). For homes without a waiting list, Creative Carers could be a particularly good investment.

What matters?

Whether or not people and outcomes really mattered was considered through the what if? testing, throughout the analysis, and especially at a team workshop on the delivery model and a manager and activity co-ordinator workshop on value. We also compared with another training model in the sector, Eden Alternative.

As a result of these reviews, some of the expected stakeholders were removed. Carers' outcomes were replaced with care home benefits because interviews indicated their experience was more professional than personal and there was the risk of double-counting. Initial thoughts about impact on local authorities and health services were also removed from the analysis, as the open questioning of stakeholders did not reveal them as a stakeholder. However we recommend they are further researched in future programmes.

In SROI practice, it's important to establish what outcomes really matter, because they are both relevant to the story and significant in impact. Because we addressed care home rather than carer benefit, the related outcome of staff morale was replaced and is captured in part by 'care is more creative and personal', and in part by workforce development.

The 'materiality' guidance above often means small returns are taken out of the Impact Model. However the rule of thumb is to see if it would make a difference to management decisions if things were included or excluded.

For this reason we include two small outcomes, sustained workforce development and artist improved creative practice.

We think the first is important to express alongside the more operational outcome of care being more creative and personal, because it indicates that culture change is required. It is an important part of the virtuous circle in which care is visibly better, and families have more peace of mind. Because three homes described very different values for this (we used the smallest) it is likely to be different in different homes. We also expect this might have a bigger, more long lasting value in any future analysis.

The second is fundamental to the ongoing development of Creative Carers as we describe above. If artists are not engaged and challenged by the work, they will look elsewhere and the programme really needs excellent artists to work. At the same time, artist development is part of Suffolk Artlink's fundamental purpose, and whilst this analysis focused on demand for Creative Carers, the next phase of development will also focus on supply. This is a recommendation below.

Finally, as we describe above, we think that the effect on residents' relationships is probably under-claimed; even though this is the outcome older people value most. In avoiding double-counting, we've prioritised the individual over social outcomes, because the individual outcomes – where care is more creative and personal - are central to the virtuous circle that creates the care home outcomes too. Whether this matters should be tested in further analyses.

Recommendations

The following are recommendations to see if the programme can create more impact, building on the existing good practice.

Delivery recommendations

- Maintain experiential learning, focus on empathy with residents and other principles of the delivery model
- Make as much use as possible of artist time in the home and develop artists to support this
- Bespoke training for each home and allow homes to do their own sharing

Evidence recommendations

- Include a baseline test for staff as part of the training day using creative methods. Train the activity co-ordinator to repeat the test later in the programme. Include guidance on resident monitoring (contact and health needs) in the training materials so staff can easily see the benefits. Include suggested use of DCM using the home's own resources (some staff are DCM trained) as sector-recognised method
- Include health and social care professionals in reviewing the story of change and gathering evidence
- Continue to collect subjective evidence. Refine surveys for residents and families/visitors and run them before and after the training programme. Now that clear outcomes have been established, ask them to report on the four resident and family outcomes and on broader indicators. For example:

  Mental activity and independence; does your relative (or do you)
  - Sleep better at night
  - Doze less during the day
  - Have meaningful relationships with care staff
  - Talk most about the past, present or future

  Better relationships; does your relative (or do you)
  - Join in with more activities
  - Feel part of a community
  - Have more family visits
  - Find there are more things to do in the home

  Families peace of mind; do you
  - Worry less
  - Spend differently on activities or care services

  Better family relationships; do you
  - Visit more
  - Enjoy your relative's company more
  - Get more involved in activities or events in the home
- Collect more objective evidence. Develop evidence collection for physical benefits by the home monitoring health and medical demands. Monitor key indicators such as waiting lists, the number of new residents entering a home who are not in crisis, willingness to pay top up fees,

complaints and comments including to CQC, length of stay. Talk to health colleagues about the use of Quality Adjusted Life Years (QALYs) to think about the quality and value of care and both physical and mental health. (nb see the upcoming report by Daniel Fujiwara which makes the case for more recognition of mental as well as physical health in the use of QALYs).

- Continue to test values, in particular, explore the relationship between social and individual outcomes and the value of workforce development
- Include visitors and residents more in outcomes by validating the results of the research with them and identifying improvements together. As well as surveying families, they could be involved in the Creative Carer training and sessions, and in focus groups to establish home practice. As we describe above, families' options are limited in terms of choosing a care home, changing to a new care home or encouraging the care home in initiatives such as Creative Caring. Consequently, they are very much in the hands of the staff and the home has a responsibility to ensure they are fully involved in their relatives plans, care and outcomes.

Impact recommendations

- Explore other parts of Story of Change for example,
  - physical impact
  - different approaches to social and individual creativity so that more residents can be involved
  - the role of the public sector at all points of the story of change; investment, delivery and outcomes, to explore whole system change
- The highest tangible value to the home comes from care being more creative and personal, so that carers can better pre-empt residents' needs releasing time to invest in other training or task. Suffolk Artlink should focus the diagnostic and objectives on this benefit, including targeting residents who would both enjoy and most benefit from creativity, as well as staff.
- At the same time learn about different models of delivery using the home diagnostic and comparing outcomes. For example, test results for homes with vacancies and those with waiting lists, and the difference between delivering to one or three homes.
- Continue to research impact within the context of a complex care market. Care homes are highly regulated but operating in a flexible labour market. Families purchasing decisions are limited by immediate need and geographic considerations, and they are highly unlikely to move residents once they are in a home. Public services pick up the tab when families can't, and pay for health care within care homes. Continuing to monitor the nature of supply and demand in the care sector will be important to Suffolk Artlink providing a service that homes are prepared to buy and that society values more broadly.

Appendices

Research

The main research documents used in this report are:

Baring Foundation, National Care Forum and NAPA	2011	*Creative Homes. How the Arts can contribute to the quality of life in residential care*
Joseph Rowntree Foundation	2011	*A Better Life: what older people with high support needs value*
Joseph Rowntree Foundation	2010	*Residential care home workforce development*
Mental Health Foundation	2011	*An Evidence Review of the Impact of Participatory Arts on Older People*
Northumbria University	2011	*Promoting wellbeing and combating isolation: Arts and dementia pilot project*
Suffolk Artlink, Caroline Wright	2008	*Creative Carers. A Reflective Study of the Creative Carers Programme*
Young Foundation, Yvonne Roberts	2012	*One Hundred Not Out: resilience and active aging*

DCM reports

Dementia Care Mapping

Dementia Care Mapping (DCM) is an observational tool used by care practitioners, researchers and service providers to evaluate the quality of life and quality of care of people with dementia. The observations recorded by the Mapper capture levels of behaviour and well-being in order to gain an understanding of the experience of care from the perspective of the person with dementia.

During a Dementia Care Mapping, every five minutes the Mapper will record a Behaviour Category Code (BCC) which represents what each person was mainly doing for that period of time. This is chosen from a list of 23 codes which are denoted by a letter (F= eating and drinking, E= expressive or creative activity). In each time frame the Mapper also records a Mood and Engagement (ME) Value, which represents how engaged the person is and whether their mood is positive or negative. This is represented on a 6 point scale (+5, +3, +1, -1, -3, -5).

For the Creative Carers project, Dementia Care Mapping has been used to capture the experience of adults with dementia in two care homes, Shaftesbury House and Harleston House, both homes having undergone the Creative Carers Training. Shaftesbury House was mapped three times, once during a creative activity, once during an ordinary morning in the home (Non-activity) and once after an interval of three months during another creative activity. Harleston House was mapped four times, once during a creative activity, once during an ordinary morning in the home (Non-activity) and twice after an interval of three months during another creative activity and another ordinary morning. The data results have been analysed in order to view any changes in behaviour and mood/engagement between the two occasions. Below is a summary of the findings.

The data is presented in WIB Profiles and Behaviour Profiles for both the group and on an individual basis. The WIB Profiles reflect the level of well/illbeing throughout the sessions; the Behaviour Profiles demonstrate the percentage of time the individuals/group spent in each behaviour category throughout the sessions.

Full details of the BCC and ME codes and values can be found at the end of the report.

Behaviour Category Codes:

A = Articulation - Interacting with others verbally or otherwise – no obvious accompanying activity

B = Borderline - Being engaged but passively (watching)

C = Cool - Being disengaged

D = Doing for self - Self Care

E = Expressive - Expressive or creative activity

F = Food - Eating or drinking

G = Going back - Reminiscence and life review

I = Intellectual - Prioritising the use of intellectual abilities

J = Joints - Exercise or physical activity

K = Kum and Go - Walking, standing or moving independently

L = Leisure - Leisure, fun and recreational activities

N = Nod Land Of - Sleeping, dozing

O = Objects - Displaying attachment to or relating to inanimate objects

P = Physical - Receiving practical, physical or personal care

R = Religion - Engaging in a religious activity

S = Sexual expression - Sexual expression

T = Timalation - Direct engagement of the senses

U = Unresponded to - Attempting to communicate without receiving a response

V = Vocational - Work or work-like activity

W = Withstanding - Repetitive self-stimulation of a sustained nature

X = Excretion - Episodes related to excretion

Y = Yourself - Interaction in the absence of any observable other

Z = Zero option - Fits now of existing categories

ME Values

+5 = The happiest, most relaxed, contented and comfortable a participant could be. It would take a lot to disengage the participant from, this activity.

+3 = There are clear signs of happiness, contentment, pleasure, relaxation and comfort but the participant has the potential for a more positive mood. The participant is considerably engaged but they may become engaged with other things for intermittent periods.

+1 = Where the mood state is neutral. The participant is alert and engaged with their surroundings, but engagement with a particular person, activity or object is brief or intermittent.

-1 = There are small signs of unhappiness, distress, displeasure, anger, anxiety, fear, discomfort, boredom. The participant is showing signs of disengagement, and is withdrawn and out of contact with their surroundings.

-3 = There are clear signs of unhappiness, distress, displeasure, anger, anxiety, fear or discomfort.

-5 = This is where a participant displays signs of very great unhappiness, distress, displeasure, anger, anxiety, fear or discomfort.

Report one

The most frequent BCC's and ME values that occurred during these mappings are as follows:

Behaviour Category Codes:	ME Values
B = Borderline - being engaged but passively (watching) **E** = Expressive - engaging in an expressive or creative activity **A** = Articulate - interacting with others verbally or otherwise **I** = Intellectual - Prioritising the use of intellectual abilities **N** = Nod Land Of - Sleeping, dozing **X** = Excretion - Episodes related to excretion	**+1** = Where the mood state is neutral. The participant is alert and engaged with their surroundings, but engagement with a particular person, activity or object is brief or intermittent. **+3** = Clear signs of happiness, contentment, pleasure, relaxation and comfort but the participant has the potential for a more positive mood. The participant is considerably engaged but they may become engaged with other things for intermittent periods. **-1** = Small signs of unhappiness, distress, displeasure, anger, anxiety, fear, discomfort, boredom. The participant is showing signs of disengagement, and is withdrawn and out of contact with their surroundings.

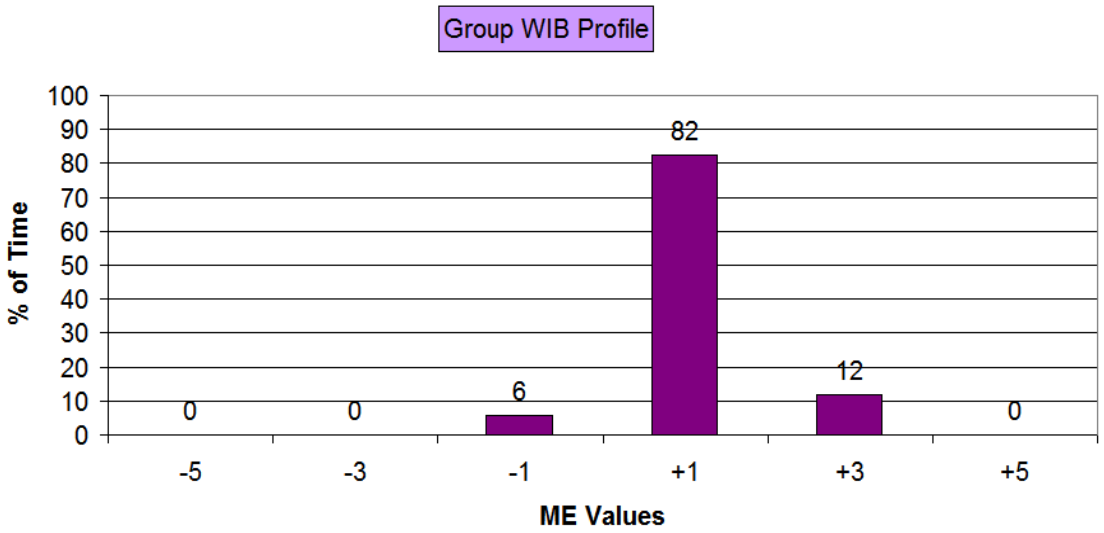
Shaftesbury House - Group Data

Below is the data collected during the Non-Activity 1, Activity 1 and Activity 2 at Shaftesbury House. The group data can be seen in the charts below; the charts demonstrate the Group's WIB (Well/Ill-being) Profile and the Group's Behaviour Profile. The group's WIB profile is the percentage of time the group spent in each Mood/Engagement Value throughout the map. The Group Behaviour profile is the percentage of time the group spent in each behaviour category code throughout the map.

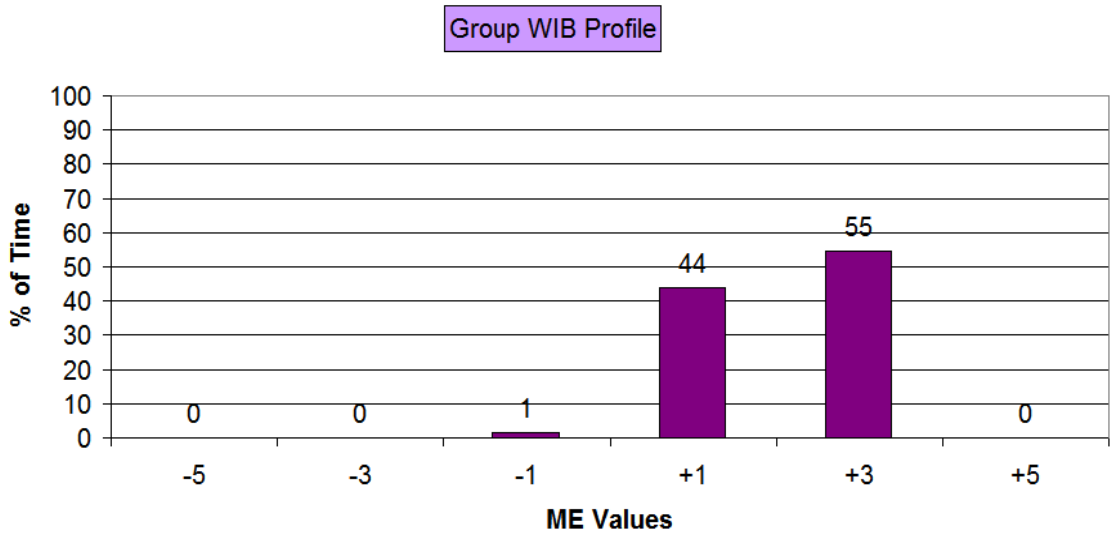
Group WIB Profiles:

The two charts below show the Group WIB Profiles for the two Maps at Shaftesbury House.

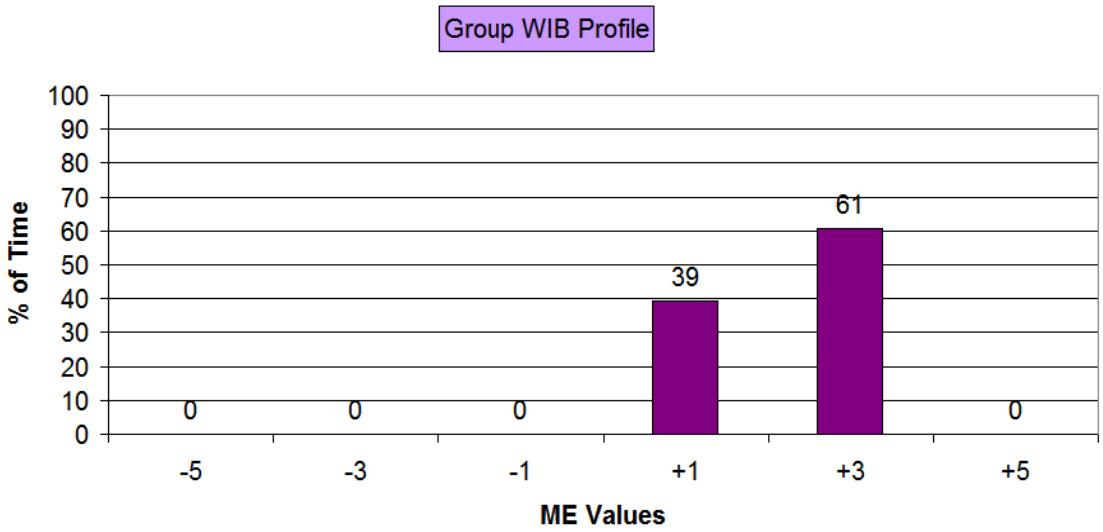
Group WIB Profile for Non-Activity 1 (Map 1):



Group WIB Profile for Activity 1 (Map 2):



Group WIB Profile for Activity 2 (Map 3):



Non-Activity 1 – Activity 1:

During the Activity the group spent 55% of the time in +3 (clear signs of positive mood and engagement), the group only spent 12 % of their time in +3 during the Non-activity.

During the ordinary morning the group spent 6% of the time in -1, a negative Mood/Engagement value, during the Activity they only spent 1% in a -1 ME.

These results suggests that the group were more engaged and in a more positive mood when taking part in the Activity than they were during the Non-Activity.

Activity 1 – Activity 2:

During Activity 1 the group spent 55% of the time in +3, this increased to 61% of the time spent in +3 during Activity 2.

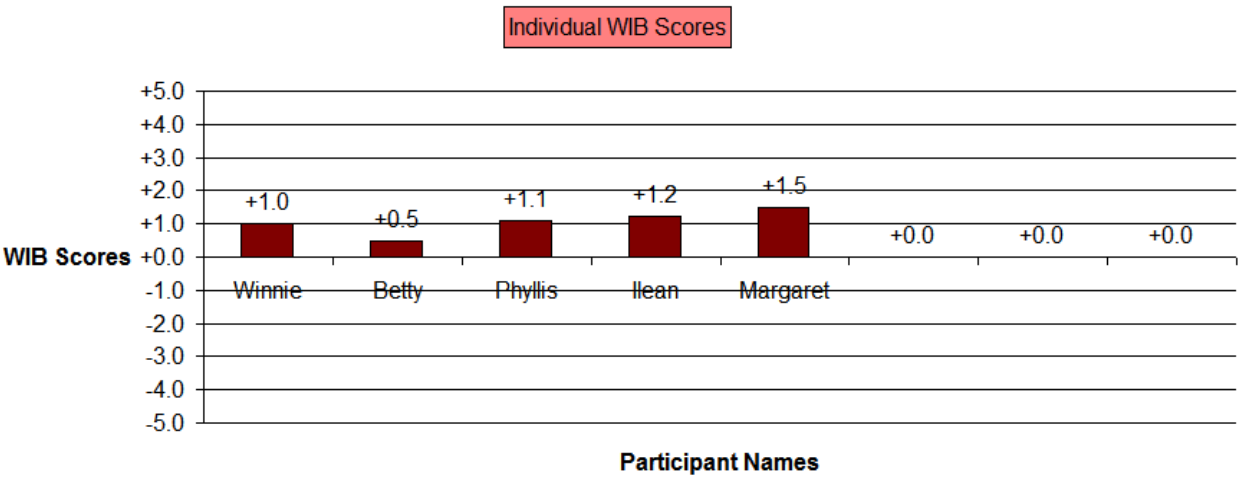
During Activity 1 the group spent 1% of the time in -1, this decreased to 0% of the time spent in -1 during Activity 2.

These results suggest a slight positive increase in the groups' mood and engagement from Activity 1 to Activity 2. This could be due to Shaftesbury House being aware of the types of activities the group enjoy most and running these more. It could also be due to the participants becoming more relaxed and confident taking part in creative activities on a more regular basis.

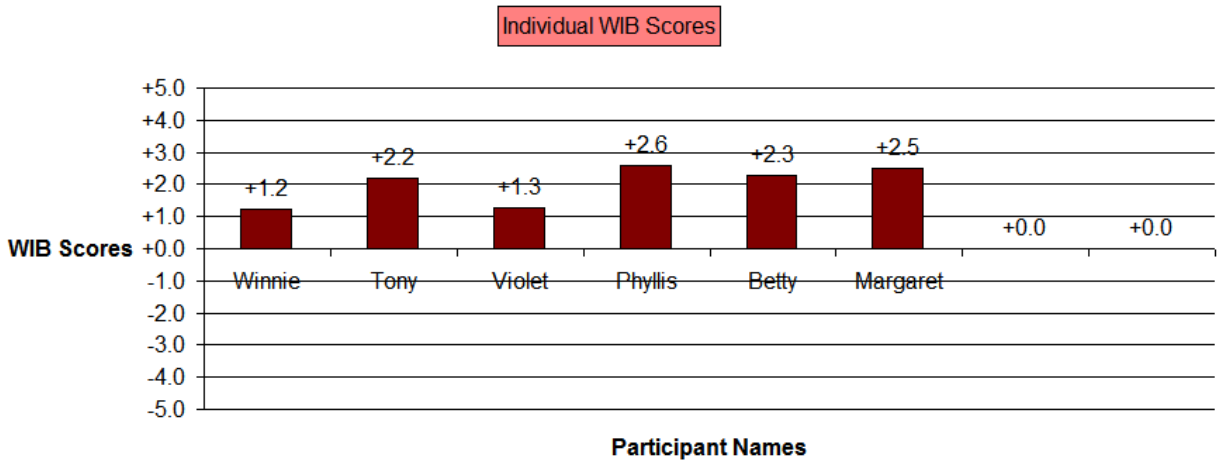
Individual WIB Scores for the Group:

The Group WIB Profile can also be viewed on an individual basis to show any differences in Mood/Engagement for all individuals in the group.

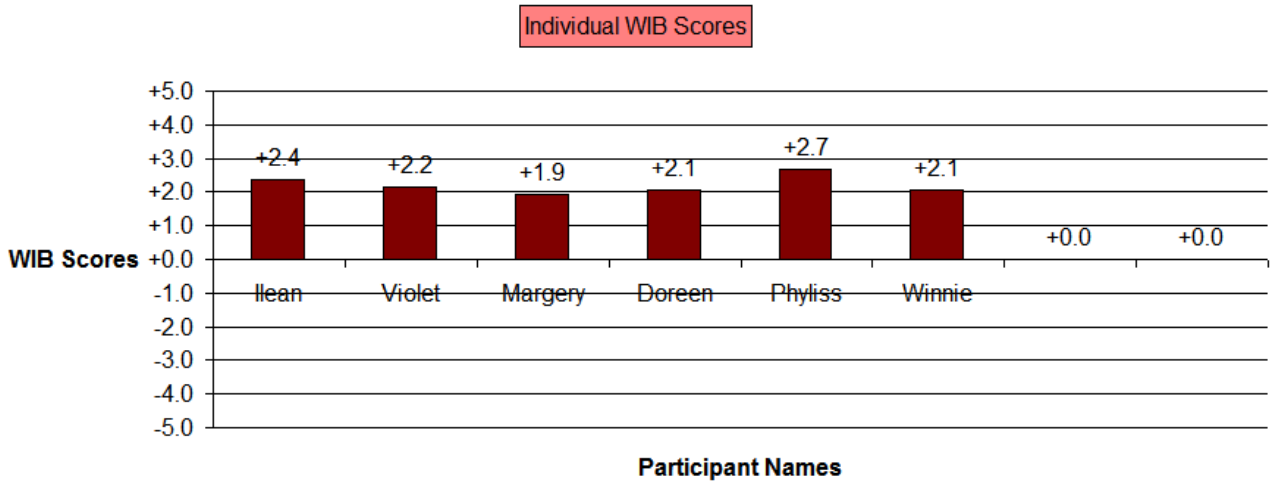
Individual WIB Scores during the Non-Activity 1 (Map 1)



Individual WIB Scores during the Activity 1 (Map 2)



Individual WIB Scores during the Activity 2 (Map 3)



Non-Activity 1 – Activity 1:

Viewing the individual WIB Scores for the whole group clearly shows the difference in Well/Ill-being between the Activity and Non-activity.

For each individual their level of Mood/Engagement was more positive during the activity than during the Non-activity. For example, Margaret's WIB score was +1.5 during the Non-activity and was +2.5 during the Activity.

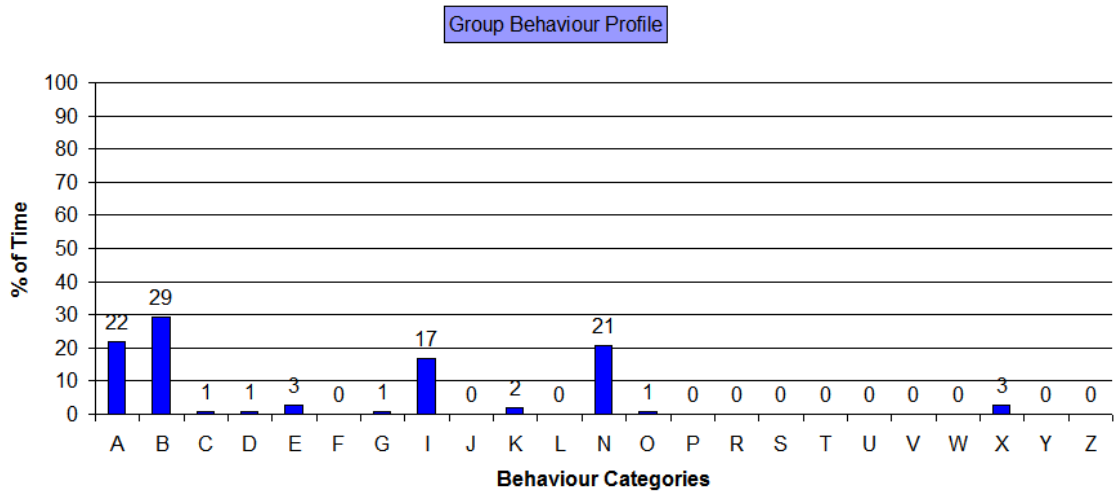
Activity 1 – Activity 2:

For the participants who it was possible to map for Activity 1 and Activity 2, a small increase in their WIB scores can be seen between the two activities. This could be due to Activity 2 being an activity that these participants enjoy more than Activity 1. It could also be due to the participants becoming more relaxed and confident taking part in creative activities on a more regular basis.

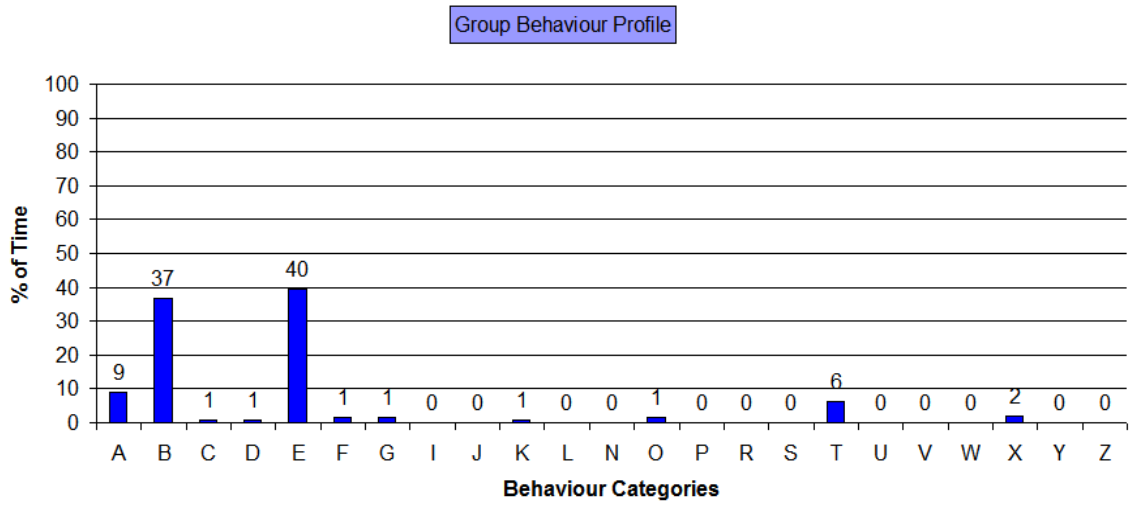
Group Behaviour Profiles:

The two charts below show the Group Behaviour Profiles for the three Maps at Shaftesbury House.

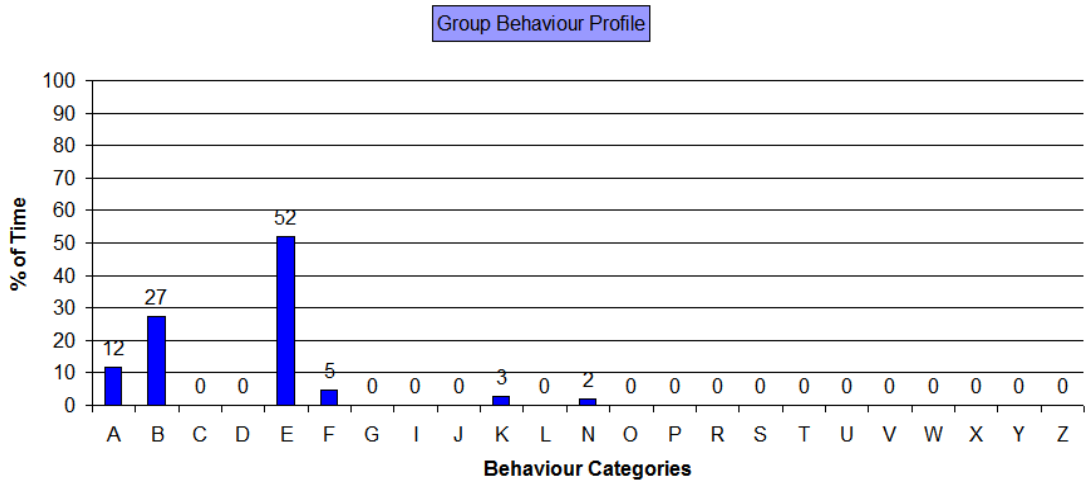
Group Behaviour Profile for Non-Activity 1 (Map 1):



Group Behaviour Profile for Activity 1 (Map 2):



Group Behaviour Profile for Activity 2 (Map 3):



Non-Activity 1 – Activity 1:

These charts display the behaviour categories that were recorded during the Activity 1 and Non-Activity 1. The most common behaviours in the Non-Activity 1 were: B (passively engaged, watching), A (talking to other or following another's conversation), N (sleeping) and I (Intellectual) as a member of staff did a small quiz for some of the time period. The most common behaviours recorded during the Activity 1 were: E (taking part in a creative activity), B (passively engaged, watching) and A (talking to other or following another's conversation).

During the Activity 1 the group spent 40% of the time engaged in an expressive activity, during the Non-Activity 1 the group spent 3% of the time engaged in E. However, during the Non-Activity 1 a member of staff did conduct a small quiz, the group spent 17% of the time in I.

During Activity 1 when the group were not actively engaged in E they spent 37% of the time in B - passively engaged. During the Non-Activity 1 the group were passively engaged in things that were going on around them for 29% of the time.

Despite there being a quiz going on during the Non-activity 1, the group spent 21% of their time in N – sleeping. During the creative activity the group did not spend any time in N. This suggests that the group found the creative activity more engaging and stimulating than the quiz, they did not lose interest in the activity even when passively observing.

Activity 1 – Activity 2:

The most common behaviours recorded during Activity 2 were: E (taking part in a creative activity), B (passively engaged, watching) and A (talking to other or following another's conversation. During Activity 1 the group spent 40% of the time engaged in an expressive activity, whereas during Activity 2 the group spent 52% of the time spent in E – a slight increase in time spent engaged in an expressive activity. During the Activity when the group were not actively engaged in E they spent 37% of the time in B - passively engaged, this decreased to 27% in Activity 2 suggesting they spent more time activity engaged in Activity 2 than they did in Activity 1.

Again, this could be due to Activity 2 being an activity that the group enjoy more than Activity 1. It could also be due to the participants becoming more relaxed and confident taking part in creative activities on a more regular basis.

Report two

Harleston House - Group Data

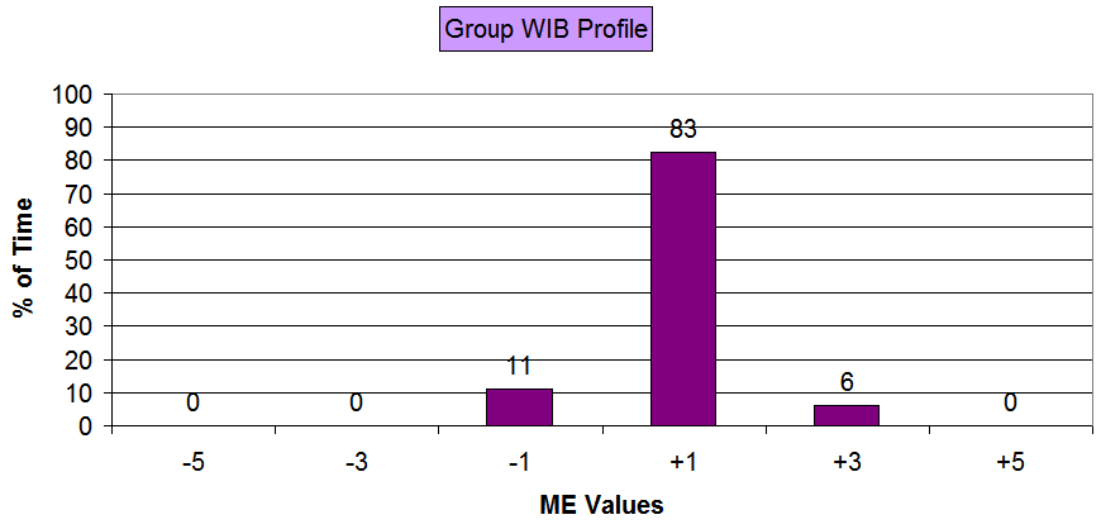
Group WIB Profiles:

Below is the data collected during Non-Activity 1, Activity 1, Non-Activity 2 and Activity 2 at Harleston House. The group data can be seen in the charts below; the charts demonstrate the Group's WIB (Well/Ill-being) Profile and the Group's Behaviour Profile. The group's WIB profile is the percentage of time the group spent in each Mood/Engagement Value throughout the map. The Group Behaviour profile is the percentage of time the group spent in each behaviour category code throughout the map.

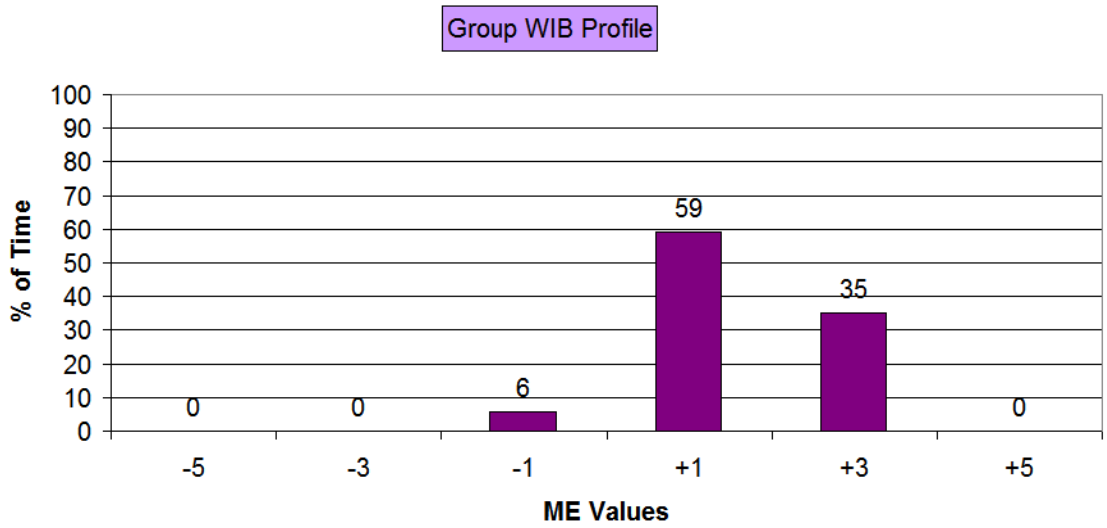
Group WIB Profiles:

The two charts below show the Group WIB Profiles for the two Maps at Harleston House.

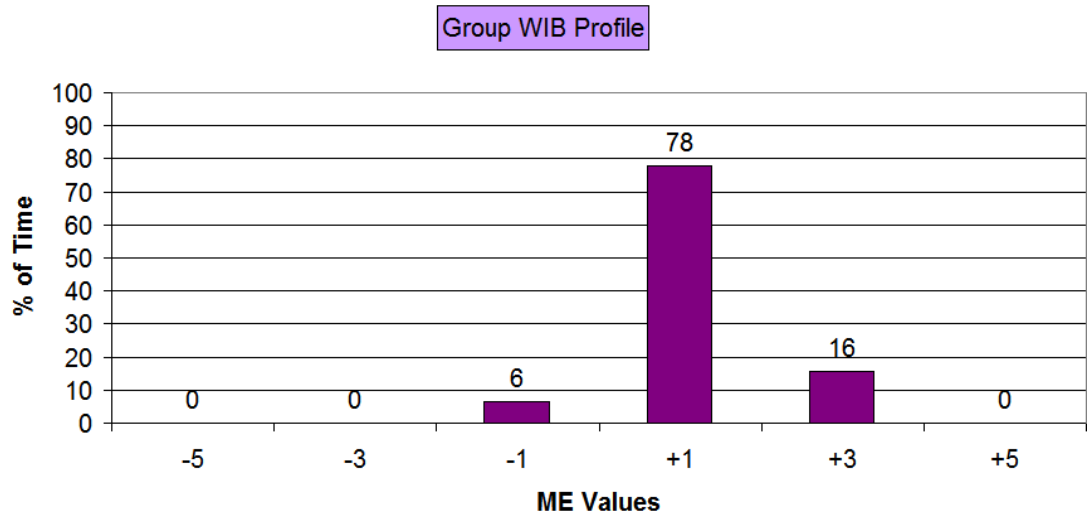
Group WIB Profile for Non-Activity 1 (Map 1):



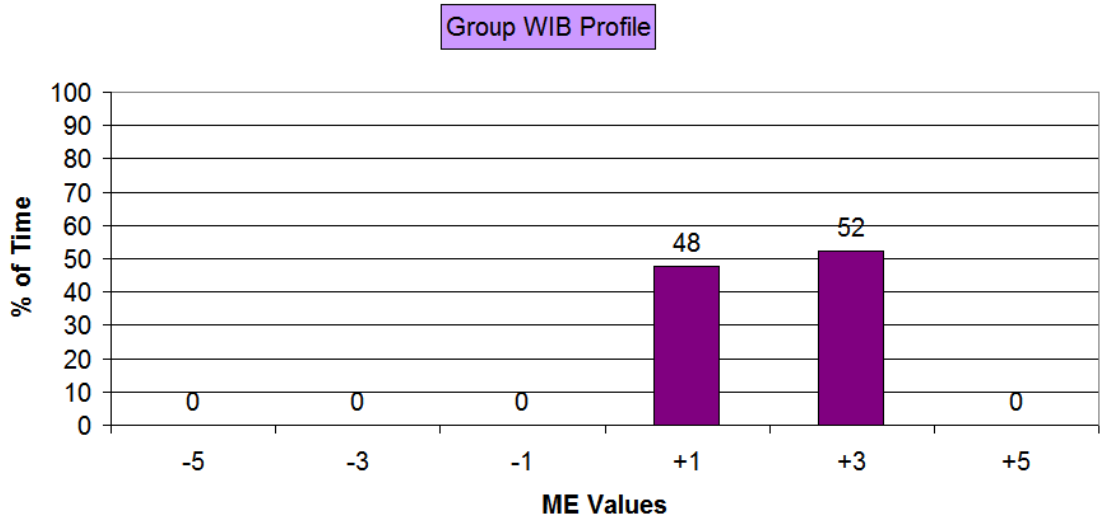
Group WIB Profile for Activity 1 (Map 2):



Group WIB Profile for Non-Activity 2 (Map 3):



Group WIB Profile for Activity 2 (Map 4):



Non-Activity 1 – Activity 1:

During Activity 1 the group spent 35% of the time in +3 (clear signs of positive mood and engagement), the group only spent 6% of their time in +3 during Non-activity 1.

During the ordinary morning the group spent 11% of the time in -1, a negative Mood/Engagement value, during Activity 1 they only spent 6% in a -1 ME.

These results suggests that the group were more engaged and in a more positive mood when taking part in Activity 1 than they were during Non-Activity 1.

Activity 1 – Activity 2:

During Activity 1 the group spent 35% of the time in +3, this increased to 52% of the time spent in +3 during Activity 2.

During Activity 1 the group spent 59% of the time in +1, this decreased to 48% of the time spent in +1 during Activity 2.

During Activity 1 the group spent 6% of the time in -1, this decreased to 0% of the time spent in -1 during Activity 2.

These results suggest a positive increase in the group's mood and engagement from Activity 1 to Activity 2. This could be due to Harleston House being aware of the types of activities the group enjoy most and running these more. It could also be due to the participants becoming more relaxed and confident taking part in creative activities on a more regular basis.

Non-Activity 1 – Non-Activity 2:

During Non-activity 1 the group spent 6% of their time in +3 (clear signs of positive mood and engagement), in Non-Activity 2 the group spent 16% of the time in +3.

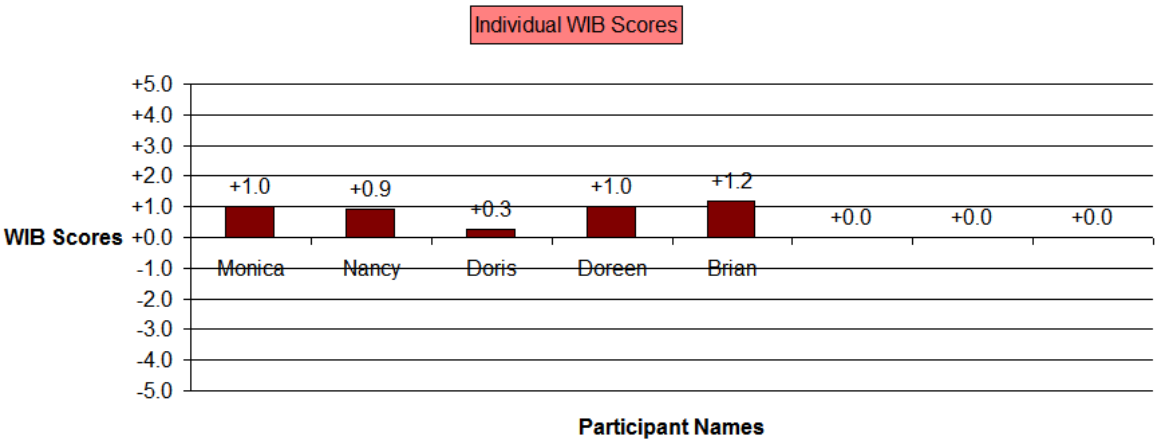
During the ordinary morning the group spent 11% of the time in -1 (small signs of unhappiness, distress, discomfort, boredom), during Non-Activity 2 they spent 6% of time in -1.

These results suggest that there was a small positive increase in engagement and positive mood during Non-Activity 2 than during Non-Activity 1. This could be due to increased engagement in creative activities over time; it could however be due to the individuals' mood on the day of mapping. Further mapping would help to clarify these results.

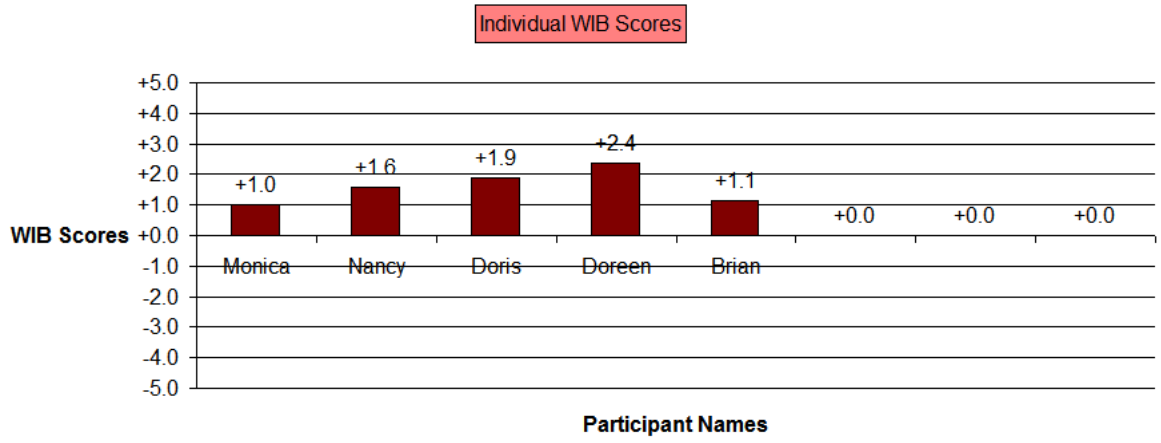
Individual WIB Scores for the Group:

The Group WIB Profile can also be viewed on an individual basis to show any differences in Mood/Engagement for all individuals in the group.

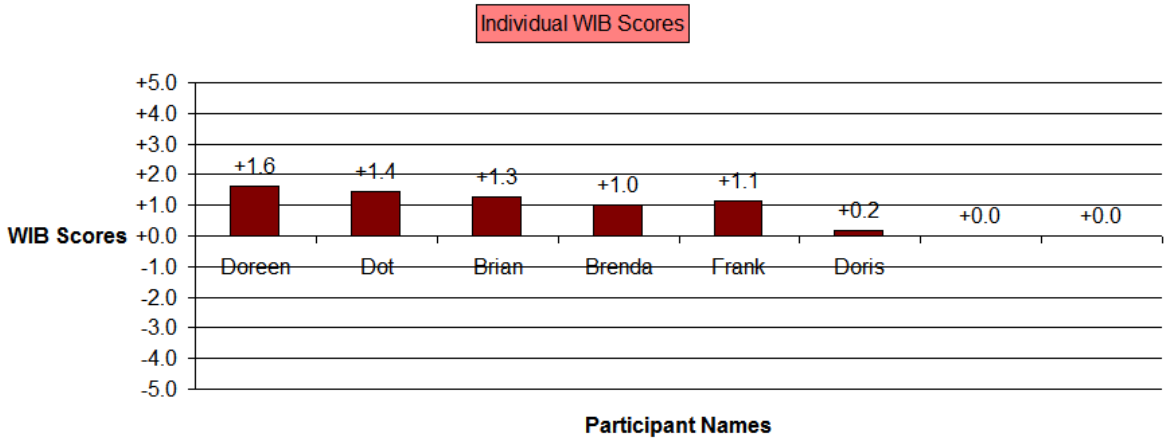
Individual WIB Scores during the Non-Activity 1 (Map 1)



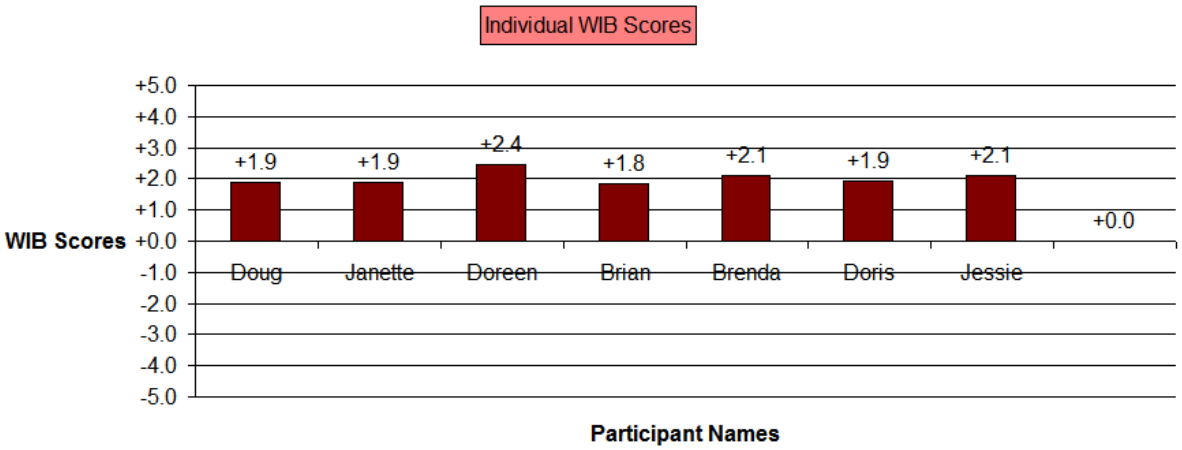
Individual WIB Scores during the Activity 1 (Map 2)



Individual WIB Scores during the Non-Activity 2 (Map 3)



Individual WIB Scores during the Activity 2 (Map 4)



Non-Activity 1 – Activity 1:

Viewing the individual WIB Scores for the whole group shows the difference in Well/Ill-being between the Activity 1 and Non-activity 1.

For most individuals their level of Mood/Engagement was more positive during the activity than during the Non-activity. For example, Doreen's WIB score was +1.0 during Non-Activity 1 and was +2.4 during Activity 1.

Activity 1 – Activity 2:

For the participants who it was possible to map for both Activity 1 and Activity 2 any changes to their levels of engagement can be seen. A small increase in WIB scores can be seen between Activity 1 and Activity 2 for one participant, the other two stayed at the same level. This could be due to Activity 2 being an activity that some participants enjoy more than others. It could also be due to the participant whose WIB score increased becoming more relaxed and confident as a result of taking part in creative activities on a more regular basis. The two participants whose WIB score remained the same still showed an increase in WIB between Activity 2 and Non-Activity 2, they perhaps just found Activity 1 and Activity 2 equally engaging.

Non-Activity 1 – Non -Activity 2:

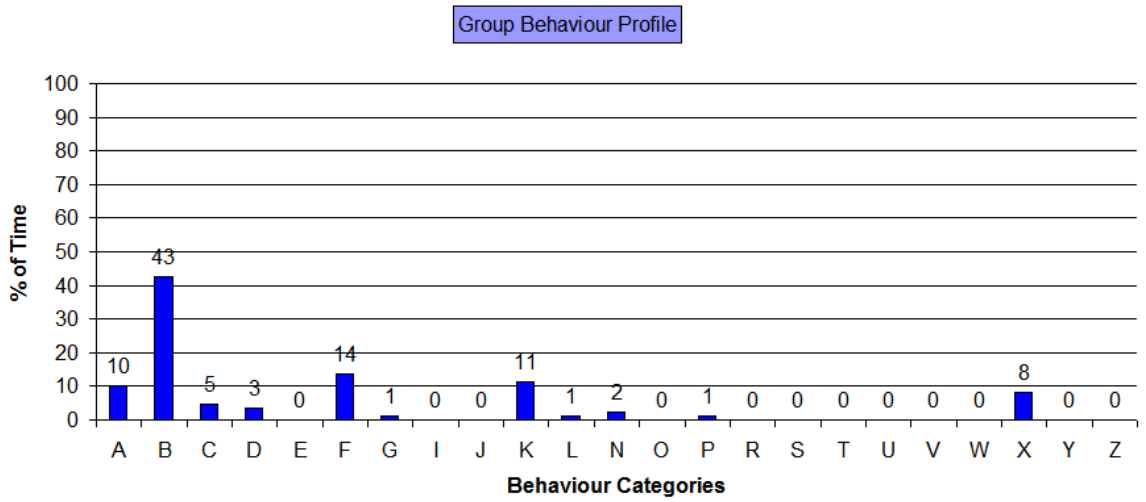
For the participants who it was possible to map for both Non-Activity 1 and Non-Activity2 two out of the three did show a small increase in WIB score. For example, Brian's WIB score in Non-Activity 1 was +1.2, in Non-Activity 2 his WIB score was +1.3.

This increase could be due to the increased engagement in creative activities across time as Brian was more engaged in Activity 2 than he was in Activity 1. However this small change could also be down to the individual's mood on that day. Further mapping would help to clarify this.

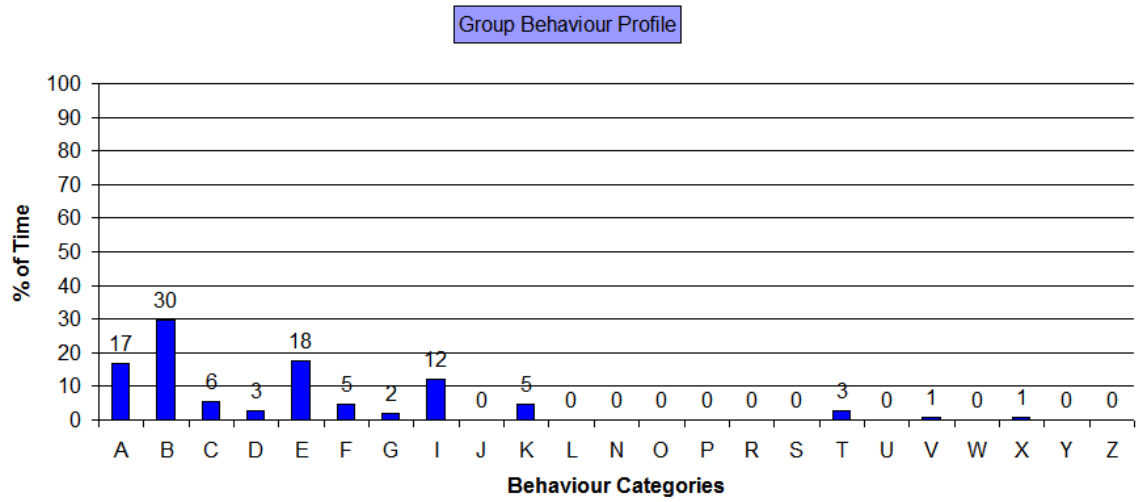
Group Behaviour Profiles:

The two charts below show the Group Behaviour Profiles for the two Maps at Harleston House.

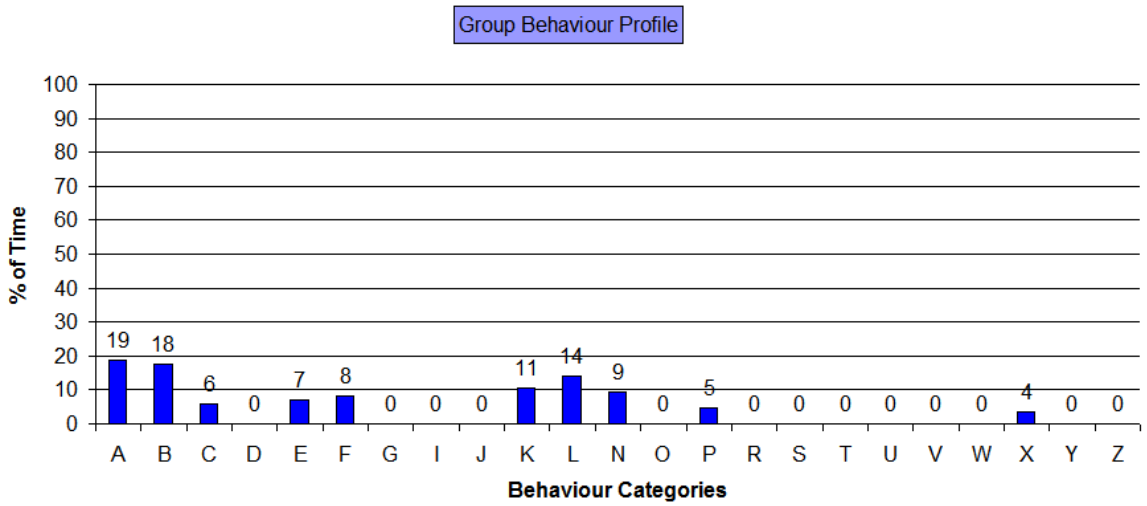
Group Behaviour Profile for Non-Activity (Map 1):



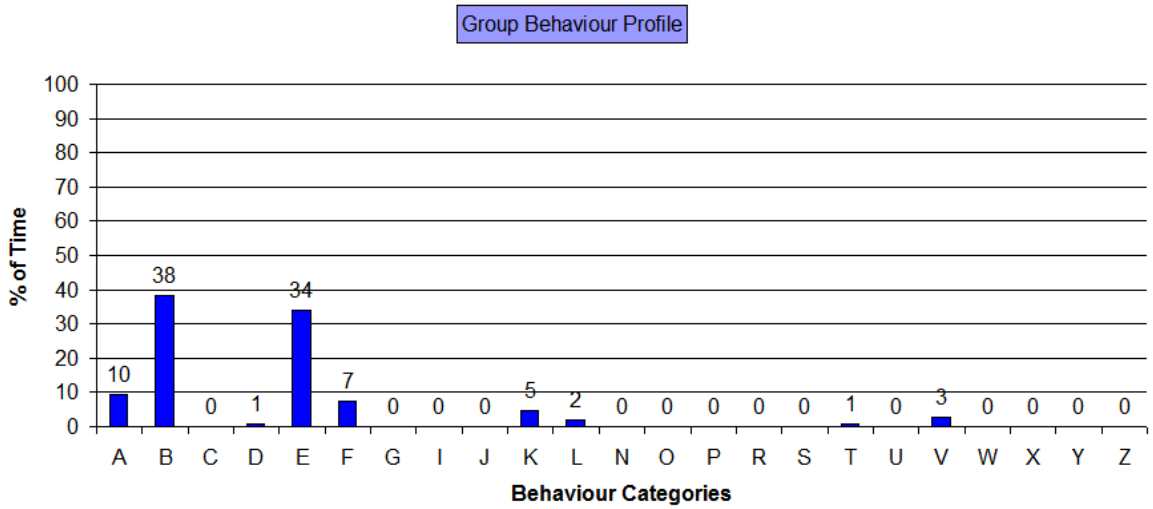
Group Behaviour Profile for Activity 1 (Map 2):



Group Behaviour Profile for Non-Activity 2 (Map 3):



Group Behaviour Profile for Activity 2 (Map 4):



Non-Activity 1 – Activity 1:

These charts display the behaviour categories that were recorded during the Activity 1 and Non-activity 1. The most common behaviours in the Non-activity 1 were: B (passively engaged, watching), F (food, eating), K, (walking, standing or moving independently), and A (talking to other or following another's conversation). The most common behaviours recorded during the Activity 1 were: B (passively engaged, watching), E (taking part in a creative activity), A (talking to other or following another's conversation) and I (use of intellectual abilities) – as they did a quiz as part of the activity.

During Activity 1 the group spent 18% of the time engaged in an expressive activity, during the Non-activity the group spent 0% of the time engaged in E. Additionally, during Activity 1 a member of staff conducted a quiz as a result the group spent 12% of the time actively engaged in I.

During Activity 2 when the group were not actively engaged in E or I they spent 30% of the time in B - passively engaged. During the Non-Activity the group were passively engaged in things that were going on around them for 43% of the time.

Activity 1 – Activity 2:

The most common behaviours recorded during Activity 2 were: B (passively engaged, watching), E (taking part in a creative activity), and A (talking to other or following another's conversation. During Activity 1 the group spent 18% of the time engaged in an expressive activity, during Activity 2 the group spent 34% of the time spent in E.

Non-Activity 1 – Non-Activity 2:

The most common behaviours recorded during Non-Activity 2 were: B (passively engaged, watching), N (sleeping), L (taking part in a leisure activity) and A (talking to other or following another's conversation.

During Non-Activity 1 the group spent 43% of the time in B, in Non-Activity 2 this decreased to 19%.

In Non-Activity 2 the group spent 14% of the time in L, during Non-Activity 1 the group only spent 1% of the time in L.

During Non-Activity 1 the group spent 10% of the time in A, in Non-Activity 2 this decreased to 19%, suggesting that the group were more frequently engaged in conversations during.

However during Non-Activity 2 the group spent 9% of the time in N, compared to only 2% spend in N during Non-Activity 1.

These results suggest that the group spent slightly less time passively engaged and more actively engaged during Non-Activity 2, however the group spent more time in N during Non-Activity 2 than they did in Non-Activity 1. These results do not show any clear changes in mood and engagement as a result of taking part in creative activities over time, further mapping would be needed to clarify this.

Activity descriptions

Activity 1 Harleston House:

Baking activity – making a crumble. When the crumble was taken to the oven the staff led a quiz. There was music on in background – some singing along and dancing.

Activity 2 Harleston House:

Baking activity. Short painting activity – painting and hand/finger printing. Then leisure activity – indoor bowls.

Activity 1 Shaftesbury House:

Creative Carers Activity – sensory task – feeling objects in bags, guessing what they are – describing feel, texture etc. Attributing descriptive words to objects – hard, soft, hot, cold, smooth etc. Then using coloured card to create shapes that link together – producing one large instillation.

Activity 2 Shaftesbury House:

Singing with keyboard accompaniment. Songs the group members know, they requested their favourites.

Surveys

Survey for artists

Thinking about Creative Carer delivery:	Please delete all but one response					Any comments?
	Not at all	Not much	So-so	A little	A lot	
Creative Carer delivery was intended to focus on process over product. How important is this?	✗✗	✗	-	✓	✓✓	
Creative Carer delivery was intended to be flexible, with both practical and emotional needs of residents and homes kept in mind. How important is this?	✗✗	✗	-	✓	✓✓	
Creative Carer delivery should have had the commitment of the manager for whole home involvement. How important is this?	✗✗	✗	-	✓	✓✓	
Creative Carer delivery should have been delivered by empathic artists with existing experience and their own ways of working with vulnerable people. How important is this?	✗✗	✗	-	✓	✓✓	
Was there any other investment you needed to make to be part of the project? Either financial or in terms of						

your practice?					
Did you get to work with people you're not used to working with?	✗✗	✗	-	✓	✓✓
Did you get to share with care staff in both directions, so you learnt from them as well as vice versa?	✗✗	✗	-	✓	✓✓
Is there anything else you think delivery should include?					
Did Creative Carers make any difference to you?					
Did Creative Carers lead to you trying any new approaches?	✗✗	✗	-	✓	✓✓
Did Creative Carers cause you to reflect on your own practice?	✗✗	✗	-	✓	✓✓
Do you continue to reflect on your own practice as a result of Creative Carers?	✗✗	✗	-	✓	✓✓
Did Creative Carers prompt any developments in your practice?	✗✗	✗	-	✓	✓✓
Have you been able to use any learning with other participants (not older people?)	✗✗	✗	-	✓	✓✓

If you have, how often would you say? Is it a daily, weekly or monthly affect?	✖✖	✖	-	✓	✓✓
And are you sure that's down to Creative Carers, or could it be something else you've been learning from?					
Do the changes have a value to you? Imagine you had a budget for your CPD. How much would you spend on what you got from CC?					
Did Creative Carers make a difference to anything else? Any unexpected or unwanted outcomes?					

Survey for staff

	Please circle any that apply				Any comments?
What is included within your job?	Helping residents with personal care	Helping residents with quality of life	Helping with activities	Work behind the scenes	

Thinking about your experience of Creative Caring	Please circle one response					Any comments?
	Not at all	Not much	So-so	A little	A lot	

Do you have the SKILLS to work creatively with residents?	✗✗	✗	-	✓	✓✓
Do you have the CONFIDENCE to work creatively with older people?	✗✗	✗	-	✓	✓✓
Are you interested in working creatively with older people? Do you WANT TO?	✗✗	✗	-	✓	✓✓
HAVE you worked creatively with residents at all? Do you get the chance to practise?	✗✗	✗	-	✓	✓✓
Is it NORMAL, EVERYDAY activity to work creatively with residents?	✗✗	✗	-	✓	✓✓
Have you worked with the Creative Carers approach? If so, since when?					
If you have worked with the Creative Carers approach, have you managed to make sure there's a focus on the present and even future, not just the past?	✗✗	✗	-	✓	✓✓

	Circle those that apply				
If you've worked with the Creative Carers approach, have you had the chance to share your approaches and learn from others?	Not at all	In your home	In your home group	With other care homes	Please explain how
Is the whole home involved with	Managers?	Admin & 'non-care'	Activity co-	Team	Carers?

Creative Caring?		staff?	ordinators?	leaders?		
	Please circle one response					Any comments?
	Not at all	Not much	So-so	A little	A lot	
If you've worked with the Creative Caring approach, does it challenge you? Does it take you out of your comfort zone?	✗✗	✗	-	✓	✓✓	
Is there anything else you'd like to say about Creative Carers?						
Do you feel creative?	✗✗	✗	-	✓	✓✓	
Are you able to initiate Creative Caring yourself?	✗✗	✗	-	✓	✓✓	
Do you feel you can do things you think need doing at work?	✗✗	✗	-	✓	✓✓	
Do you take up training and development opportunities that are offered to you?	✗✗	✗	-	✓	✓✓	
Is there anything else you'd like to say about you and your skills?						
Do you volunteer for activities that you aren't required to do? Trips and socials	✗✗	✗	-	✓	✓✓	

for example?					
Are you happy in your work?	✗✗	✗	-	✓	✓✓
Do you like working with the rest of the staff?	✗✗	✗	-	✓	✓✓
Are residents willing to participate? Are they disappointed when activities finish?	✗✗	✗	-	✓	✓✓
Do residents enjoy organised creative activities?	✗✗	✗	-	✓	✓✓
Are most residents happy?	✗✗	✗	-	✓	✓✓
Are most of the calls on your time by residents for attention, or more worthwhile engagement?	Attention seeking	A bit of attention seeking	Neither	A bit of worthwhile engage-ment	Worthwhile engage-ment
Are most residents active?	✗✗	✗	-	✓	✓✓
Do most residents have good relationships with other residents?	✗✗	✗	-	✓	✓✓
Is there anything else you'd like to say about your care home or the residents?					

Interview with managers

How many residents?					
How many staff?					
What sort of training do you do, how do you procure and how much do you spend? What sort of recruitment and induction do you do?					
What would you pay for Creative Carers?					
Do your staff have the skills to work creatively with residents?	✗✗	✗	-	✓	✓✓
Do they get the chance to practise?	✗✗	✗	-	✓	✓✓
Have staff understood that Creative Carers is about the process rather than the end product?	✗✗	✗	-	✓	✓✓
Do you have plans and records of Creative Caring we could look at? And have copies?					
Do staff have the chance to share approaches and learn from others?	Not at all	In your home	In your home group	With other care homes	Please explain how
Has the whole home been involved?	Managers?	Admin & 'non-care'	Activity co-	Team	Carers?

		staff?	ordinators?	leaders?	
Has anything from the programme been included in your formal structures and processes? Can we have copies?	In JDs or recruitment?	In induction?	In training?	In supervision?	In any other way?
Is there anything else you'd like to say about Creative Carers?					
Thinking about the staff skills					
Do you think your carers are creative?	✖✖	✖	-	✓	✓✓
Do you think carers are empowered? Are they keen to take up development opportunities? Do you have records of voluntary training and would they show us anything?	✖✖	✖	-	✓	✓✓
Has Creative Caring prompted any change? Is there anything else you'd like to say about carers, and their role?					
Thinking about your care home					
What is staff turnover?					
What sort of demand is there for jobs?					
What is the demand for places at your care home?					

Do most staff volunteer for activities that they aren't required to? Trips and socials for example?	✗✗	✗	-	✓	✓✓
Do staff seem happy in their work?	✗✗	✗	-	✓	✓✓
Do most staff work together well?	✗✗	✗	-	✓	✓✓
How frequent are social events?	✗✗	✗	-	✓	✓✓
Is there a community spirit?	✗✗	✗	-	✓	✓✓
How many residents join in with organised creative activities?	None	1 to 3	4 to 8	9 to 15	More
Thinking about residents					
Is the nature of calls on carers time more about seeking attention, or more worthwhile engagement?	✗✗	✗	-	✓	✓✓
How much medication/health care do the residents in our sample group require?					
Do the residents in our sample group have regular family visits?	✗✗	✗	-	✓	✓✓
Is there anything else you'd like to say about your care home or the residents?					
We are planning some Dementia Care Mapping with a couple of homes. Would that work do you think? Would you be					

willing?

Survey for residents

Do you have any particular needs that the home supports you with?					
Thinking about the home	Please circle one response				
*	Not at all	Not much	So-so	A little	A lot
Do you think your carers are creative?	✗✗	✗	-	✓	✓✓
Does the home feel like a creative place?	✗✗	✗	-	✓	✓✓
Is the home a social place?	✗✗	✗	-	✓	✓✓
Is there a community spirit?	✗✗	✗	-	✓	✓✓
About your experience	Not at all	Not much	So-so	A little	A lot
Do you want to participate in organised activities?	✗✗	✗	-	✓	✓✓
Do the activities really capture your attention? Are they absorbing?	✗✗	✗	-	✓	✓✓

Do you get to try out new things?	✗✗	✗	-	✓	✓✓
Do you get to re-discover old skills or abilities?	✗✗	✗	-	✓	✓✓
Do you enjoy organised activities?	✗✗	✗	-	✓	✓✓
Which activities have you enjoyed most in the past?					
About you	Not at all	Not much	So-so	A little	A lot
Do you find you sleep much in the day?	✗✗	✗	-	✓	✓✓
How well do you sleep at night?	✗✗	✗	-	✓	✓✓
Do you think most about the past, present or future?	Past		Present		Future
How active are you?	✗✗	✗	-	✓	✓✓
How much support do you need with your health?	✗✗	✗	-	✓	✓✓
How healthy would you say you are?	✗✗	✗	-	✓	✓✓
How much do your family visit?	Very rarely	Rarely	Every so often	Often	Very often
Do you have good relationships with other residents?	Very poor	Quite poor	So-so	Quite good	Very good

Survey for visitors

What is your relationship with the person you visit here?						
How independent is the person you visit here? Do they have any long term needs?						
Thinking about the care home	Please circle one response					Any comments?
	Not at all	Not much	So-so	A little	A lot	
Would you say the care staff here are creative?	✗✗	✗	-	✓	✓✓	
Does the home feel like a creative place?	✗✗	✗	-	✓	✓✓	
Is the home part of the community? If so, in what way?	✗✗	✗	-	✓	✓✓	
Do you have any suggestions for things that could be done better?						
Thinking about the person you visit here						
Do they seem really involved in the organised activities?	✗✗	✗	-	✓	✓✓	
How much do they enjoy the organised activities?	✗✗	✗	-	✓	✓✓	
How happy would you say they are?	✗✗	✗	-	✓	✓✓	
How healthy would you say they are?	✗✗	✗	-	✓	✓✓	PTO

Thinking about your relationship with the person you visit					
How much do you visit?	Very rarely	Rarely	Every so often	Often	Very often
How good would you say your relationship is with the person you visit?	Very poor	Quite poor	So-so	Quite good	Very good
If you would like to know more about the home or get involved, please give us your contact details and we'll get in touch.					
Thank you very much for your help in improving our home.					

About Ladder to the Moon

Ladder to the Moon provides workforce and service development that enables health and care organisations to develop active, creative, vibrant care services. Ladder to the Moon's work uses approaches that incorporate creativity and arts, involving staff, older people living with dementia and other long-term conditions, and the wider community.

The company, which operates as a social enterprise, was established with support from the Department of Health Innovation Fund. Through working with Ladder to the Moon, organisations improve activity provision and quality of life outcomes, achieve high levels of staff engagement and differentiate themselves in the marketplace.

"NCF members working with Ladder to the Moon have found that they can make a profound and positive difference to the way their homes operate"

Des Kelly OBE, Executive Director, National Care Forum

The approach in action

Ladder to the Moon development programmes raise levels of activity and engagement by delivering a series of creative community events, alongside training and coaching. Lasting up to 12 months, the programmes establish new ways of working and maintain momentum as creative, active care grows across the setting.

The company also offers training courses that equip staff with the tools and inspiration needed to lead and deliver a vibrant activity culture. The range of courses offers high quality facilitation from creative professionals and coaches, along with unique creative 'Film Shoot' experiences and practical assignments in applying creative thinking.

Case study

Queen Elizabeth House is a 28-bed high-performing Greensleeves home in Bromley. Ladder to the Moon worked with the whole staff team to improve trust and teamwork and enable the staff to improve wellbeing of several residents whom staff found it more difficult to engage.

Sarah was felt to be a languishing resident who has improved through the programme, Asvinta, Home Manager, says:

"We've moved her three quarters of the way up the flourishing scale. There has been only one episode of difficult behaviour since the Ladder programme. The staff know how to approach her now. Before Ladder, we would have labelled her 'challenging behaviour' but not now. We use the tools Ladder to the Moon taught us - very simple things make all the difference and now she is smiling and laughing much of the time."

Staff across the home are engaging with all residents in new ways, such as sharing pictures of football teams with a sport-loving resident, encouraging visiting relatives to dance with residents and using baththimes as a trigger for discussing memories of swimming and the seaside. Kitchen staff who were on the Ladder training team are also now more involved with residents, for example, spending time with residents when serving tea.

Asvita reflected on the impact of the programme:

"Staff are very positive. Junior staff are taking the initiative in ways they would not have done before, and this load balancing opens up their jobs and their opportunities for personal growth and enjoyment as well as for helping residents to flourish."

More information online: www.laddertothemoon.co.uk

 Contact: 0207 794 2593 relationship@laddertothemoon.co.uk

References, sources, rationale

Context

[i] The Academy of Medical Sciences, 2009, Rejuvenating Ageing Research

[ii] The Young Foundation, Yvonne Roberts, 2012, *One Hundred Not Out: resilience and active aging*

[iii] Alzheimer's Society, 2007 Dementia UK

[iv] Institute of Fiscal Studies, 2010, *Financial circumstances, health and wellbeing of the older population in England*

[v] C Victor, S Scahmberm A Bowling, J Bond, CUP 2005, *The prevalence of and risk factors for loneliness in later life*

[vi] *One Hundred Not Out*, as above

[vii] Kings Fund, cited by Young Foundation, 2012 as above

[viii] OECD, 2011, *Help wanted? Providing and paying for long-term care*

[ix] Care Bill, 2013

[x] The Law Commission has proposed streamlining current legislation into a single act for adult social care including core principles which support 'active aging'.

[xi] Care Quality Commission, 2011/12, *The state of health care and adult social care in England*

[xii] Care Quality Commission, 2009

[xiii] Skills for Care, 2008

[xiv] The Baring Foundation, National Care Forum, National Association of Activity Providers for Older People, 2011, *Creative Homes. How the Arts can contribute to quality of life in residential care homes.*

[xv] Duration was established through consultation with current and previous participating care homes. See Impact below.

Story of Change and consultation

[xvi] Gandy R, Roe B, McClelland B et al, 2001, *The cost-benefits of end-of-life training in care homes with dementia patients,* BMJ Support Palliat Care 2011 1:83

[xvii]

Consultation and evidence collection

Stakeholder	Numbers	Method
To establish the initial Story of Change:		
Suffolk Artlink & lead artists	3	Initial scoping meeting establishing anticipated stakeholders and their outcomes
Artists	5	Establish Story of Change as part of the artist training day
Care staff (no managers)	5 homes, 14	Establish Story of Change as part of care staff training day
Care homes	5 care homes	Observation of in-home activity. Artists visited care homes five times each to work together on Creative Carers. Each time the artists sent feedback on how the care homes were progressing.
Care home managers & staff & artists	2 homes, 4 care home staff 5 artists	Observation of sharing day. All the trainees and the managers were intended to come together with the artists to share learning, however the event was poorly attended and only two homes were represented.
Care home managers	5	Observation of two training events for managers. Written Story of Change circulated for comment. Comments received from two.
To collect evidence for change and review the Story of Change. It was agreed two homes would participate in detail with further information from others:		
Care home managers	5	Face to face interviews to establish baseline with five managers, followed by four phone interviews for follow up 6 months later. Further phone calls with two managers to discuss Impact Model. Impact Model circulated for comment. Comments received from a further one manager.
Care staff	2 homes, 10 staff each (one home partial completion)	Two written surveys to establish baseline and follow up 4 months later. Two homes agreed to participate. Only one completed the baseline, both completed the follow up.
Regional manager	1	Two phone interviews requested, one completed including testing the Impact Model.
Residents	2 homes, 16 residents	Dementia Care Mapping completed three times in one home, and four times in another home. Mapping was off everyday care baseline, activity baseline, activity follow up 4 months later, (everyday care follow up in one home)
Residents	2 homes, 16 residents	Staff observation. Staff observed the residents who had been mapped to see if there were changes to the number and nature of calls they made to staff and their medical or health needs

Residents	1 home, 8 residents	Two written surveys to establish baseline and follow up 4 months later. One home was for people with dementia so it was only suitable for one home to do this.
Family	2 homes, 18 family members	Two written surveys to establish baseline and follow up 4 months later. Two homes agreed to participate. Only one completed the baseline, both completed the follow up.
Managers & activity co-ords	2 homes, 4 staff	Valuation workshop. Intended to apply values to outcomes but also amended Story of Change.
Suffolk Artlink & lead artists	3 artists	Workshop to review delivery model.
All artists	5	Email survey a year on.
National research		See list above and references below.

[xviii] The stakeholders and expected outcomes were established in a scoping meeting with the client and lead artists then updated throughout the project.

Stakeholder	Expected outcome	Established outcomes
Older people (48)	More Quality Adjusted Life Years Improved general quality of life: New social relationships Fun Improved physical well-being New opportunities Able to live more in the present, not just in the past	Residents are mentally active and more independent Residents have better social and family life
Older people's families	Living more in the present with their relatives Better value for money from the home Increased peace of mind Greater communication with carers – something else to talk about	Families get on better

Carers (16) Role specific e.g. activity leads Volunteers Paid (primary or secondary beneficiaries?)	Increased skills, confidence & job satisfaction Improved relationships / atmosphere within home Progression within job / career Life Skills – recognition of other skills from outside work	Included in care home outcomes so as not to double count
Care homes/ managers (4) Ipswich x 2 Lowestoft Essex Health & social care services	Improved staff retention and easier recruitment Improved marketability - higher quality, and visible activities Supports communication with families – creates a 'product' which makes the care visible Improved life-span of residents, so increased occupancy Reduced needs of engaged residents Reduced medication needs New understanding of value of the arts	Everyday care time spent on better quality activity Workforce development and sustained practice Better long term care of residents visible to staff and families Health and social care services removed as stakeholder because not mentioned in open consultation
Artists Lead (2) Delivery (3)	Professional development Awareness Communication skills Improved potential for employment New understanding of value/practical application of arts	Artists re-think, re-value and improve this and other creative practice
Suffolk Artlink	Kudos & profile raising Sustainability for the project Job Satisfaction	Removed from analysis as limited research was focused on business benefits and delivery model. Likely to be immaterial in comparison with the tangible values for home and high values for families
Arts Sector	Projects raise awareness of practical applications of art	
Older People's sector	TBC	

[xix] *Creative Homes* as above

[xx] Eden Alternative provides training to transform institutional approaches to care into 'caring communities where life is worth living'. http://www.edenalt.org/

[xxi] Ladder to the Moon www.laddertothemoon.co.uk

[xxii] JRF 2011, *A Better Life, what older people with high support needs value*

[xxiii] G Fleming, B Taylor, 2006, *Battle on the home care front: perceptions of home care workers of factors influencing staff retention in Northern Ireland*, Health and Social Care in the Community, Vol. 15 No. 1, pp.67-76

[xxiv] B Smith, N Kerse, M Parsons, 2005, *Quality of residential care for older people: does education for healthcare assistants make a difference?* The New Zealand Medical Journal, Vol. 118, No. 1214.

[xxv] R Proctor, H Stratton-Powell, N Tarrier, A Burns, 1998 *The impact of training and support on stress among care staff in nursing and residential homes for the elderly*, Journal of Mental Health, Vol. 7, No. 1, pp59-70

[xxvi] Report published for Care Quality Commission May 2011

[xxvii] Mental Health Foundation,2011, *An Evidence Review of the Impact of Participatory Arts on Older People*.

[xxviii] Nazroo J, Greenwadl I, Bajekal M and Lewis J, 2005, *Ethnic Inequalities in Quality of Life at Older Ages: Subjective and Objective Components* ERSC

[xxix] ONS, 2013, *Measuring National Wellbeing – Older People's Neighbourhoods*

[xxx] The Economist, Dec 16 2010, *The U-bend of life*

[xxxi] *Creative Homes* as above

[xxxii] *A Better Life* as above

[xxxiii]

Evidence

Outcome	Indicators & evidence collection
	Observations were recorded by artists and evaluators at the carer training, managers' training and 20 in-home sessions.
Residents are mentally active and more independent	Dementia Care Mapping undertaken in two care homes – three compared everyday caring with an activity, then the activity four months on. A further session in one home also mapped everyday care four months on. About 8 residents were observed each time. The nature of demands on carer time were monitored by one home formally with residents. A resident questionnaire was completed by 10 residents in one home (without dementia) once and again after four months.
Residents have better social and family relationships	Joining in more, and more family visits were estimated by homes in retrospect. This needs more systematic monitoring in future programmes, which will be achievable with greater involvement of the care home manager upfront. One home asked 10 visitors to complete a questionnaire once and then after 4 months. A second home asked visitors to complete the questionnaire at the end.
Families' peace of mind	Families peace of mind results in the main from residents' outcomes, but is only true for those who are engaged with their relatives. This is therefore applied to those who visit regularly estimated by homes at least 50%. Results were established in the main through manager interviews.
Families get on better	More family visits as above.
Everyday care time better spent	Residents' needs and calls on staff time change. One home asked 10 staff to complete a questionnaire once and after four months.
Workforce development and sustained practice Better long term care of residents visible to staff & families	Two managers and two activity co-ordinators attended a workshop. Two further managers and one regional manager were interviewed.
Artists re-think, re-value & improve this & other creative practice	Self-report use of CC learning elsewhere

xxxiv

Results

Outcome	Results
Residents are mentally active and more independent	24 residents (of 25) see a 21% improvement in their mental activity and independence. 3 residents see an 85% improvement.
Residents have better social and family relationships	5 residents have improved social and family relationships judged to be a 21% improvement in line with above.
Families' peace of mind	24 residents (of 25) see a 21% improvement in their mental activity and independence. 3 residents see an 85% improvement. Of these, half of their families experience better peace of mind.
Families get on better	2 visitors experience improved relationships judged to be a 21% improvement in line with above.
Everyday care time better spent	21 residents become more independent releasing staff for 10 minute each time a contact call is avoided. At 21% or 85% improvement this is 20 minutes or 1hr 25 minutes per resident for 24 or 3 people.
Workforce development and sustained practice	Bar a small group of resistant staff (5 out of 27) there is a whole-home change.
Better long term care of residents visible to staff & families	Whole-home change.
Artists re-think, re-value & improve this & other creative practice	All artists saw changes to their practice.

[xxxv] **Deadweight, attribution, duration**

(No displacement)

Outcome	Deadweight		Attribution		Duration	
Residents are mentally active and more independent	Most expect decline through loss of independence and reduced relationships	0%	Formal and informal contact outside the care home + care home's own attribution – estimated by managers	79%	Average home stay for residents - PSSRU, Bupa, 2011 Length of stay in care homes	2
Residents have better social and family relationships						
Families' peace of mind						
Families get on better Everyday care time better spent						
Everyday care time better spent	Closed environment so accounted for in attribution	0%	Other CPD and organisation development estimated by care home managers	68%	Mirrors residents	2
Workforce development and sustained practice					One off improvement likely to be superceded by other projects	1
Better long term care of residents visible to staff & families						
Artists re-think, re-value & improve this & other creative practice	As experimental people work generally evolves	50%	No other CPD in period	0%	Superceded by other factors	1

Valuation

xxxvi The value game uses tangible values that we know alongside harder to value outcomes so comparison by participants can rank and therefore quantify the less tangible elements.

xxxvii

Proxy values

Outcome	Proxy values		Source or rationale
Residents are mentally active and more independent	Amount resident might spend to remain independent at home	8,390	Total of:
	Installation of stair lift	5000	Stannah. Spread over two years
	Bathroom adaptation	7000	Local estimate. Spread over two years
	Cleaner or other weekly help	1350	Based on 2 hours a week at £15 an hour for 45 weeks
	Taxi use	1040	Based on two £10 fares a week for 52 weeks
OR	Cost of health and social services in very sheltered housing	16,541	PSSRU, 2009, Unit costs of health and social care
OR	Value of unpaid care per carer	15,260	PSSRU, 2009, Unit costs of health and social care
Residents have better social and family relationships	The value of increased social relationships with friends and relatives from once or twice a week, as opposed to once or twice a month.	15,500	Powdthavee, 2007, Putting a price tag on relatives and neighbours: Using surveys of life satisfaction to value social relationships.
	Older people value relationships highest of all		IPPR, 2008, Older People and Wellbeing. JRF, 2011, *A Better Life*
Families' peace of mind	Willingness to top up LA fees (£163/week)	8,450	Care manager
Families get on better	Value of unpaid care per carer	15,260	PSSRU, 2009, Unit costs of health and social care
Everyday care time better spent	Staff hourly rate	7.20	Care manager
Workforce development and sustained practice	Bonus scheme	1,400	Care manager
OR	Rise from £7.20 to £8 for care staff. Or £2K per staff member	13,500	Care manager

OR	Workforce care - e.g. meals out - five meals per year at £15 per head for all staff and residents	4,800	Care manager
Better long term care of residents visible to staff & families	Marketing spend on under-performing home	3,000	Care manager
Artists re-think, re-value & improve this & other creative practice	Typical day's workshop costs	300	Artist

[xxxviii] World Health Organisation 2007, WHO global report on falls prevention in older age

[xxxix] Age UK

[xl]

Investment values

Stakeholder	Investment value		Source or rationale
Residents and families	Part of fee spent on staffing and activities	448	Total of:
	Part of fee spent on staffing	380	Care manager: 65% of home costs
	Average spend per resident on activities	68	Baring Foundation, NCF, NAPA, 2011, *Creative Homes*
Care homes	Training fee	2,786	Cost of programme
	Staff time to train	1,344	Calculation
	Manager's time to support the training	683	Calculation based on a half day diagnostic and 9 months at half a day each month
	Number trainees	32	Average of dementia and care home staffing. JRF, 2010, Residential care home workforce development
	Hours training	6	Estimate for new programme
	Average hourly rate for cover	7.0	Care manager
Artists	No investment		Time to train offset by earnings

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A full version of this report can be found at: http://www.suffolkartlink.org.uk

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