Wellbeing through Food in Care Homes
A case study evaluation of the Food for Life programme in Edinburgh

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Executive Summary

Malnutrition, social isolation and loneliness are major personal concerns and public health issues for older people in care homes. For food in care homes, current policy in Scotland includes an emphasis on personalised dietary choice and control for residents, sociable mealtimes, and recognition of the role of food in creating community connections.

Over a fourteen-month period, the Food for Life Better Care team collaborated with staff and residents at Royston Court, Edinburgh, to focus on food and food-related activities as a social experience and a bridge to the surrounding community.

Food for Life Better Care sought to be both comprehensive – they took a whole settings approach to multiple aspects of food – and developmental – lead actors sought to test out and reflect on what worked and what did not go so well.

Care home staff were confidently able to identify positive impacts on social connections, social wellbeing, mood, diet and mealtime experiences for the majority of participants in FFLBC linked activities.

These impacts were supported by accounts of residents about making rich memories; novel, fun and exciting experiences; connections to people in new ways; and engaging in meaningful activities and making links to the local area.

The intergenerational activities were novel to both the care home and local primary school. They matched the core values of both institutions and were reported to be relatively straightforward to set up and run over time.

The intergenerational activities were popular with residents and included residents with a wide range of abilities and interests. According to staff, the feedback from children was very positive.

The gardening and growing activities helped make new volunteer and community links. The new growing areas and orchard established a longer-term legacy for the programme.

A leading benefit of the Silver Food for Life Served Here Award was for the recognition it gave to the kitchen staff in the care home.

The key challenges that the programme encountered were staff changes; staff work pressures; low interest in some activities; consistency and continuity over time; integration and links between different FFLBC activities; financial pressures on catering budgets; staff and resident awareness of the overall goals of the programme; the vulnerability and high support needs of residents that restricted opportunities to participate.

Overall, the initiative was not resource intensive. It avoided setting up unsustainable expectations and succeeded in mobilising the interests and skills of care home staff.
1. Introduction

In March 2017, Soil Association Food for Life received a £1.25 million grant from the Big Lottery Fund to develop and evaluate the Food for Life Better Care (FFL BC) programme. One of the key programme processes is to work with older people and key stakeholders to design an integrated approach to food that improves nutrition, well-being and reduces loneliness in care homes. FFLBC developed a programme of work in the areas of Edinburgh, Calderdale, Kirklees, Leicester City and Leicestershire. While each area shared a common overarching framework and approach towards engaging partners, it was anticipated from the outset that the team would adapt the delivery of the intervention to fit local circumstances. A central focus for the Edinburgh based programme and its evaluation has been to work to identify and work with one care home, Royston Court, over a fourteen-month period.

This report provides an overview of relevant research literature, and outlines the design and development of the programme before setting out details of the methods and process and impact findings from the evaluation.

1.1 Research on food and social connections in care homes

There is a growing body of research on the relationships between poor nutrition and psychological-social wellbeing for older people in care home settings. While there has been extensive research on interventions with a focus on specific nutritional outcomes, there are few reports on the role of holistic food initiatives in care home settings.

Malnutrition presents a significant health threat to care home residents. A narrative review on nutrition in residential care facilities found that on average, half of residents in residential care homes were malnourished (Agarwal et al., 2016). In the UK, over one-third of care home residents have been found to be malnourished and requiring treatment (BAPEN, 2015). Malnutrition in care homes is associated with high healthcare cost, largely as a result of healthcare use including GP consultations, hospitalisations, healthcare monitoring and treatments (Abizanda et al., 2016). In addition, adverse outcomes of malnutrition include risk of infections, mortality, falls, pressure ulcers, anaemia, hospital admissions and poorer quality of life (Arvanitakis et al., 2008; Neyens et al., 2013; Shah et al., 2013; Ulger et al., 2013; Agarwal et al., 2016; Noronha et al., 2015; Sahin et al., 2016). Figure 1 illustrates the relationship between malnutrition and multiple poor health and social consequences.

Living in care homes is one of the risk factors to loneliness among older people (Savikko et al., 2005; Age, 2014). Moreover, over one-third of care home residents report feeling lonely at least sometimes (Jansson et al., 2017). There is growing research and interest on loneliness among older people (Courtin and Knapp, 2017). Loneliness can be described as the feeling that results from a person’s perceived inadequacy in his or her relationships (Lopata, 1969; Weiss, 1973). There are two main dimensions to loneliness – emotional and social loneliness. While emotional loneliness is the lack of a long-lasting close relationship to other people (Lopata, 1969; Weiss, 1973); social loneliness arises from the lack of meaningful friendship (Creecy, Berg and Wright, 1985; Larson, 1990). Loneliness is closely related, but conceptually distinct, from social connectedness and social isolation. Thus, whereas social isolation and social connectedness are
more objective states of inadequacy of the number of social contacts that an individual has, loneliness involves subjective feelings of one’s close relationships (Weiss, 1973; Chappell and Badger, 1989; Cornwell and Waite, 2009). In other words, an individual may be surrounded by a large number of social network, and yet, feel lonely.

Figure 1: Food in Care Settings for Older People: a set of interlinked problems

Moreover, loneliness has severe consequences for the health and wellbeing of older people. Older people who perceive themselves to be lonely are more likely to experience poorer quality of life (Arslanas et al., 2015). Loneliness significantly correlates with poor functional status, poor self-reported health (Cohen-Mansfield et al., 2016) and lower perceived quality of life scores (Ausín, Muñoz and Castellanos, 2017). Loneliness is a significant risk factor for depression among older people (Peerenboom et al., 2015), even after controlling for confounding factors such as stress, objective social isolation, social support or dispositional negativity (Cacioppo, Hawkley and Thisted, 2010). Loneliness also significantly correlates with lower resilience and lower life satisfaction (Zebhauser et al., 2014). Loneliness leads to the development of dementia (Kuiper et al., 2015); incidence of cardiovascular diseases (Thurston and Kubzansky, 2009) and can also lead to death (Holt-Lunstad, Smith and Layton, 2010; Luo and Waite, 2014).

Correlations between loneliness, malnutrition and adverse well-being outcomes among older people in care homes warrants the need for effective interventions to improve the well-being of older people in care homes. There is emerging, but relatively little, research on food-related interventions to improve well-being of older people in the care home setting. Hence, a whole
setting approach using food is warranted in this area. A Whole Settings Approach (WSA) to food means using food to improve care right across a care setting to include various aspects of food growing, eating and cooking as well as connecting people and the wider community (Food for Life, 2018). A WSA directly delivers one of the key objectives of improving the experience of older people residing in care homes – potentially boosting an interest in food, increasing appetite, supporting mobility and enhancing overall nutritional intake of older people (Agarwal et al., 2016; Hutchison, 2012; Keller, Beck and Namasivayam, 2015; Watkins et al., 2017).

A whole settings approach can provide access to therapeutic food and growing activities and intergenerational activity which have shown to be of benefit to the health and well-being of care home residents, carers and visitors, and to reduce experience of loneliness for older people (Tse, 2010; de Boer et al., 2017). Nevertheless, there is only a paucity of research on whole settings-based interventions on food to improve the diets and wider health and well-being of older people.

1.2 Policy and practice context
The proportion of people in Scotland aged 75 years and more is expected to increase by 60 percent by 2033. This population age group uses health and social care services the most; and their predicted rise in numbers will transform into more than 70 percent increase in health and social care expenditure by 2033. These challenges will exacerbate the impact of inflation on health and care services. Disease patterns among older people are expected to continuously shift towards long-term conditions due to people living longer and older people having multiple and complex health conditions including dementia. The Scottish population affected by dementia is set to rise by 44 percent by 2033 (Scottish Government, 2013).

Scotland’s care landscape has been changing over the years. Similar to past policies, current legislation and planning processes have focused on enabling people to live independently for longer in their own homes (ScottishCare, 2018). Scotland’s health and social care policies are geared towards more personalised, individual choice and control, better integration of services and improved efficiency through public purchasing. For instance, the Social Care (Self-directed Support) Act 2013 wove individual choice and control into the planning, assessment, delivery and commissioning of care and support. The Act presents a service delivery model where service users direct their preferred type of care and when they want it (Social Care Act, 2013). Moreover, the Public Bodies (Joint Working) (Scotland) Act 2014 seeks to integrate health and social care services at local and national levels. It requires every health and social care partnership, with the engagement of other local partners including independent sector providers to create and implement integration plans. These partnerships are meant to ensure local strategic commissioning and planning. They are responsible for addressing the challenges and opportunities encountered by the Scottish social care sector, including the role of care homes which are part of social care services within local communities (Public Bodies Act, 2014). Furthermore, the Procurement Reform (Scotland) Act 2014 was introduced as a national legislative framework to ensure that purchasing of services are based on ideas which consider best value, individual outcomes and rights and procurement regulations to ensure an improved, sustainable procurement process. This affects the way social care services commissioned by public bodies are procured (Procurement Reform Act, 2014).
The social care sector, particularly care home sector, is facing continuous pressures and challenges in the provision of social care. For example, the Reshaping Care for Older People Programme 2011-2020 found significant delays in hospital discharge (‘bed-blocking’). One of the reasons behind these delays is the less availability of social care packages because of the sector’s limitation in capacity and resources (Convention of Scottish Local Authorities, 2011). An increasing ageing Scottish population means that the pressures on the social care sector, especially the care home sector, is escalating. Care homes therefore have a crucial role to play in driving positive outcomes and efficiency for the Scottish health and social care system (ScottishCare, 2018).

Although there have been efforts to improve the quality of care in care homes in Scotland over the years, there are still some aspects of care that require improvements. A report of the Care Inspectorate (2017) on inspection of all care homes in Scotland between 2016 and 2017 examined the quality of care based on the extent to which care homes met the Standards of Care for Dementia in Scotland. The report shows that one-tenth of care homes failed to create opportunities to keep residents active and engaged. Only sixty-percent of care homes implemented the enablement approach of the standards where people with dementia were supported to attain personal goals and meaningfully engage with their environment and integrate with their community. Forty-five percent of care home staff reported that the lack of engagement of residents with dementia was due to lower staffing levels. Although most care homes had private gardens, residents could not access these independently and had to rely on staff for assistance. There were opportunities to develop the relationship between staff and residents through innovative and interactive tasks.

In June 2010, the Scottish Social Services Council (SSSC) and NHS Education for Scotland (NES) developed a framework to meet the targets and actions outlined in the Scottish Government’s National Dementia Strategy. The NES/SSSC framework presents the knowledge and skills staff in health and social services should pursue to adequately support people living with dementia, their carers and families (Scottish Social Services Council, 2011). The framework uses quality of life outcome indicators to measure the impact of the support health and social care staff should provide. The framework’s quality of life indicators includes promoting best levels of physical, mental, social and emotional wellbeing for people with dementia. It also includes helping people with dementia to maintain links with their communities and engaging in valued activities.

Service regulation in Scotland has been recently reformed through the Health and Social Care Standards. The Health and Social Care Standards came into effect in April 2018 to replace the National Care Standards, published in 2002. The Health and Social Care Standards (2018) outline individual rights and wellbeing expectations of people who use health, social care or social work services in Scotland and this includes older people in care homes. The standards aim to ensure that the way people are cared for is improved, flexible and innovative.

The standards consist of five headline outcomes each of which has principles in improving the wellbeing of service users. Thus, to ensure that service users experience the right quality care and
support, service users should have options for an active lifestyle and take part in several social, physical, creative, learning and recreational activities routinely, both indoors and outdoors. Service users must be able to choose well-served nutritious meals and snacks and be involved in menu planning. Where service users need assistance with eating and drinking, this should be given in a dignified manner and their personal preferences considered. They should be able to enjoy their mealtimes in a relaxed environment. Meals need to be culturally acceptable and service users must have opportunities to grow, cook and eat their own food where possible (Health and Social Care Standards, 2018).

The Health and Social Care Standards (2018) also expects people to use services that are well managed and led and where service users are confident that they are cared for by competent staff. The standards encourage innovative ways in providing care and support to service users. The standards recommend adequate physical space that meets the needs and wishes of residents’ access to a private garden.

1.3 The Food for Life Better Care whole settings programme in care homes

The Food for Life (FFL) programme was originally developed by the Soil Association in 2003 to help schools take a WSA towards improving multiple aspects of food in educational environments. Since 2014, the Soil Association have extended the FFL programme in to other settings such as care homes, hospitals, children’s nurseries, and universities. In 2017, the Soil Association received funding from the Big Lottery Fund to focus on improving the food environment for older people in a range of contexts. This provided the opportunity for FFL to further develop its work with care homes through collaborating with specific providers in three areas of the UK.

The Food for Life Care Home framework is intended to relate to a wide range of aspects of food in care homes. A briefing document from the early stage of the programme states, “We will co-design frameworks, training programmes and resources that support a whole setting approach to the provision of nutritious sustainable food. The education and engagement of residents and their families, staff and wider community will aim to enable and inspire people to be involved in their food, eat well and achieve nutritional care”

The framework consists of the following domains: (1) catering quality, (2) resident food experience, (3) therapeutic food related activity, (4) community and partnerships, and (5) leadership for a health-promoting care setting. FFL sets these domains out as co-design training and support packages to cover the areas set out below.

1. Make nutritious, locally sourced sustainable food and drinks available around the clock
   1.1 Training chefs and cooks to be able to plan menus that meet nutritional needs, using recognised tools such as Food for Life Served Here award.
   1.2 Set up chef networks for recipe sharing – new popular seasonal recipes
   1.3 Support chefs to be able to prepare food to meet special dietary requirements such as modified textured food, enriching food for those with poor appetites

2. Improve eating and dining environments
   2.1 Support independence in eating by providing appropriate equipment and food
2.2 Ensure dining environment is attractive, calm and inviting
2.3 Have menus on display for all to read
2.4 Provide opportunities for residents to engage with mealtimes e.g. make suggestions of favourite dishes; assist with table setting; drying dishes, polishing cutlery
2.5 Well trained, attentive and adequate staff
2.6 Ensure crockery is contrasting colour to table clothes and not patterned so those with dementia can see the food and are not confused

3. Involve all residents and staff with all food related activities in the care home and outside
3.1 Stimulate the sense and reminiscence activities through touch, feel, smell of plants and flowers through growing and cooking activities
3.2 Hen keeping activities

4. Make links with the wider community
4.1 Gardening activities with local groups e.g. families, schools and early years settings
4.2 Sharing mealtimes with other friends and family in the home and outside through shared meal providers
4.3 Organise visits to care farms, community gardens and garden centres

5. Improve leadership for a health-promoting care setting
5.1 Adopting management level accountability for nutrition and hydration policy
5.2 Engaging a wider workforce

Figure 2: Food for Life Better Care: Framework for a whole settings approach in care homes
1.4 The programme ‘theory of change’
The original programme theory of change emphasises the importance of coordinating change in parallel across a number of different domains within the care home setting. Such improvements in these domains of the care setting are intended to increase the satisfaction of residents in food-related activities, decrease their risk of malnutrition and loneliness, leading to an improvement in their well-being. In turn if residents’ well-being is improved, then residents’ relatives are more likely to be satisfied with the quality of care at the care homes. Equally, resident and family quality of life is enhanced, this will have positive impacts for staff and volunteer job satisfaction at the care homes and boost their morale to help make further improvements. The care homes theory of change, developed at the outset of the programme, is in the Appendix.

1.5 Study setting
The FFLBC’s WSA is being implemented in Royston Court in the north west of Edinburgh. Royston Court is a newly built (2017) 60 bed capacity care home. It is one of 10 care homes owned by the local authority which, following close working with NHS Scotland, comes under Edinburgh Integrated Joint Board [Edinburgh Health and Social Care Partnership]. It has a kitchen on-site and grounds surrounding the main building. The home has brought together residents and staff from other homes that have since been re-purposed or closed. The home is located within the Granton and Royston Mains area of Edinburgh, which is in the 2nd decile of the Scottish Index of Multiple Deprivation, meaning it sits within the highest 20% of deprived areas with particularly high income and education/skills deprivation. The home is in close proximity to a sheltered housing residence, a primary school and local shops. In late 2018, the breakdown of the staffing in the care home was as follows:

- 1 Manager, 1 Depute, and 2 Team leaders
- 4 Social Care Workers and 14 Social Care Assistants
- 1 Senior cook, 1 Cook, and 2 Cook Assistants
- 2 Administrators, 2 Maintenance Officers, 4 Domestic Staff, and 1 Laundry Assistant

Staffing is planned on a basis of 18 care staff per 56 residents in the daytime, and 10/56 at night time. Three District Nurses provide additional nursing support.

The home divides into four units. Two first floor units are for the frail elderly (1:5 staff ratio): two ground floor units, one for dementia and one for stress/distress (both 1:4 staff ratio). Due to staff shortages, the management had temporarily closed the home to new residents in the summer of 2018: of the 60 units available, 56 were occupied.

Towards the end of the evaluation period, in November 2018, the 56 residents at the care home had the following profile:

- 35 females and 21 males.
- A mean of 23.4 months resident in residential care homes (range 1-66 months).
- Approaching two thirds (63%) residents were on a special diet, including a fortified, pureed, diabetic, finger food and smooth diet.¹

¹ May 18
• MUST scores indicated high overall levels of dietary needs: 38 ‘low’ (score 0), 10 ‘medium’ (score 1), 6 ‘high’ (score 2), 2 ‘bedbound’ (n=56).

The Dietetic and Catering Advisor, at Edinburgh Council, identified Royston Court as a potential care home to take part in the FFLBC programme. FFBC made initial approaches early autumn 2017 and, following agreement, started briefing and planning meetings in November of that year.

Over the course of the programme, the care home was in the process of addressing a Care Inspection Report in March 2018 that gave ratings of ‘Quality of environment’ and ‘Quality of management and leadership’ as Weak; and ‘Quality of care and support’ and ‘Quality of staffing’ as Adequate. At a follow up visit in December 2018, the Inspectorate found some improvements to the quality of the service.

1.6 Research aim and questions
This evaluation sets out to present a robust and transparent account of the processes, learning, and impact of the FFL BC WSA in a care home setting for residents, residents’ relatives, staff and volunteers. The aim of the evaluation is to examine the implementation, context and perceived effects of the programme. The evaluation is designed to answer the following research questions:

1. What are the characteristics, context and processes of implementation of a whole setting approach to food in a care home?
2. What are the perceived effects of the FFL BC approach to food in a care home on the health and well-being of residents, staff and other parties?

2. Research methodology and methods

2.1 Study methodology and design
The evaluation uses case study methodology and design (Yin, 2003), drawing upon multiple data sources including staff interviews and programme documentation. The evaluation follows a realist approach (Pawson and Tilley, 1997), where we sought to identify the underlying processes or mechanisms that have brought about change in the outcomes of the WSA and the way the context has influenced these outcomes. This process-oriented evaluation led to the development CMO (context-mechanism-outcome) configurations used in Realist Evaluation (Pawson et al., 2004). Consequently, the evaluation led us to assess the initial programme theory of change (see Connell and Kubisch, 1998) regarding the role of an integrated and co-designed whole setting approach to food in care home settings.

2.2 Involvement of care home residents and relatives
The areas of focus for the research were developed through a resident, public and practitioner consultation process in Edinburgh prior to, and at the early stage of, the programme award. The FFL BC programme team and care home staff have led on further consultations with residents and relatives regarding the future development of the programme. Within the short time frame of the research we were not able to take the research protocol through a National Social Care Research Ethics Committee. This meant that we did not have permissions to collect personal
data from residents and relatives. The focus of this study is therefore on the perspectives of care home staff and other practitioner stakeholders.

2.3 Interview eligibility, selection and recruitment

All care home staff and volunteers, and programme staff were eligible to take part in the evaluation. With respect to care home staff, this included those not directly linked to programme activities. Reasons for exclusion included absence from work or a new appointment to the staff role. We sought to select staff with a range of different roles in the care home, including those with roles for care support, social activities, mealtime provision, nutritional support, staff development, management and leadership. We also requested interviews from programme staff, volunteers and staff from partner agencies linked to the programme.

In total, we conducted 20 interviews with 16 individuals. These comprised of 2 managers; 2 team leaders; 2 social care workers; 5 social care assistants; 1 cook; 2 programme staff; 1 education practitioner from an outside agency; 1 local authority dietetics and catering advisor. The care home did not have staff with a dedicated role for coordinating activities.

2.4 Interview process and data collection tools

Staff took part in semi-structured interviews to explore their perceptions of the development, implementation, context, and perceived outcomes of the programme. The interviews lasted approximately 30 minutes (range 17-120 minutes). Key staff such as managers and programme leads were interviewed over more than one occasion. Interviews were conducted by a member of the evaluation team (SI or AD) on the premises of the care home in a quiet environment, or by telephone. We developed a semi-structured interview schedule to guide individual interviews with staff and volunteers (see appendix). This included a proxy questionnaire tool to collect anonymised information about residents and their engagement with programme related activities from the perspective of staff. Where appropriate, we used the proxy tool to record information with regard to all residents at the final stage of the programme. This tool was adapted from Fancourt and Poon’s (2016) practitioner observation tool for arts-based activities in care home settings. Overall, the staff interviewed had considerable knowledge about the residents during their period in care. As an indication of this, the average duration that staff interviewees had known each resident was 17 months, and the average duration of residents’ stay in care home(s) was 23 months.

2.5 Programme documentation and data collection tools

The programme was monitored through capturing key aspects of its delivery. These aspects included programme inputs (financial and other resources); programme engagement with agencies; programme activities and outputs (such as number of training events delivered) and programme interim outcomes such as uptake of the project activity being carried out. The appendix sets out the programme data capture tools.
2.6 Data recording and analysis
Qualitative data collected from the interviews was audio-recorded and transcribed verbatim by the UWE. All transcripts were analysed thematically using procedures proposed by Clarke and Braun (2014) with the help of the NVIVO 11 software (QSR International, 2018).

We used the context-mechanism-outcome configuration as the framework for our realist analysis. First, we arranged all data according to our initial programme theory. Thus, we organised our data in the domains of the implementation of the WSA, the context, mechanisms, outcomes and actors. Secondly, we explored the mechanisms that have led to the outcomes using both our process, monitoring and outcome data. We then determined the context in which the mechanism did or did not generate the outcomes. In this regard, we specifically looked at the sub-groups of our sample based on the demographic information obtained. We then derived context-mechanism-outcome statements from this analysis. Finally, we determined which CMO configurations presents the most credible account of the identified patterns in our outcomes. We then compared this configuration with the initial programme theory.

2.7 Ethical Issues
The University of the West of England’s Research Ethics Committee granted ethical approval for the evaluation (ref: HAS.17.08.004). Informed consent was sought from the all participants. They were provided with an information sheet detailing their role in evaluation of the WSA and give them the opportunity to clarify any information regarding the evaluation (see Appendices). Potential participants were given a consent form to sign to document their agreement to take part in the study if they are willing to take part. Consent was treated as on-going and participants could withdraw from the evaluation at any time without any penalty or reason for withdrawal. Data already collected from participants who withdraw from the evaluation was kept with agreement from the participants. Participants were made aware that the data they provide would be anonymised at the point of transcription or file entry of questionnaires, and stored securely on university computer servers. The data is stored only for the appropriate time required for its use and in accordance with the General Data Protection Regulation (GDPR, 2018).

3. Process evaluation findings: Context, model and implementation of the programme
3.1 Summary of FFLBC activities delivered
The FFLBC team engaged with Royston Court between November 18 and February 2019. During this time, the following activities were linked to the implementation of the programme:

Food Quality
- The care home was awarded Silver Food for Life Served Here Award. This involved a full catering audit and review, and new procurement practices with a local, organic fruit and vegetable supplier.

Staff training
- Introduction to a Whole Settings Approach to good food event
- Therapeutic Food Activity training / workshop attended by the Catering Manager for all homes
- Staff training for Dementia Friendly Dining
Gardening and Growing

- Plan for gardens developed by local growing expert, paid for by Better Care, in conjunction with residents and staff.
- New growing space – orchard, involving residents in choosing and planting trees.
- New growing space – raised beds and vegetable plots
- Equipment supplied for garden for free by Scottish Allotment Growers Society – organised by volunteer gardener.
- Further activities including staff engagement around benefits of using outside space

Cooking and food activity

- Harvest from raised bed involving cook and residents
- Offer of a cooking pack*

Intergenerational Activity

- Local school & nursery visited the care home for growing activities
- Visit organised to Royal Botanic Gardens Edinburgh with residents and P6 pupils (aged 9 & 10) with a range of activities in the gardens.
- Offer to support a Roast Dinner Day*

Community visits and interactions with relatives

- The Botanic Gardens visit
- Interaction with school/nursery
- Interaction with local community growing group
- Resident families and staff engaged through information leaflet sent out about changes within Royston Court

* The home declined to take up the offers in relation to the cooking pack and Roast Dinner Day
* A plan to run a baking activity did not go ahead due to low take up or interest

3.2 Context to the delivery of the programme

During the course of the programme there were a number of wider issues that had a bearing on the delivery of activities. One long-term trend has been that growing pressures in the system mean that residential homes are taking on older people with higher level of needs than had historically been the case.

A lot of older people are staying at home for longer and so by the time they do come into care their needs are much more complex and much more specialised. [MN]

Thus care homes were increasingly focused on managing high level support for residents. This placed pressures on the care sector to maintain programmes on social, therapeutic and preventative activities.

There is high staff turnover within the sector. There had been a major local drive to recruit new staff and, as part of a local authority initiative, early interventions to support staff off sick.

We’ve been relying on agency cover. Sometimes you’ll get different agency people every day and when you’re trying to build up some continuity for the residents when it’s different staff coming in every day who are not familiar with the residents it does make it a lot harder to really provide what you really want to do for the residents. So it’s been an ongoing challenge. [DM]
During the period of the programme, there was scrutiny on the care home from the Health and Social Care Partnership and the Care Inspectorate. The latter noted issues with care planning, staff training, and awareness of malnutrition indicators. More widely, there had also been quite a lot of change in the wider organisation partnership with an integration of social care and NHS management.

There were pressures on food and drink budgets with price rises above inflation. New managers with a background in the NHS have been looking at expanding a centralised cook-chill facility to supply hospitals and care homes across the area. Although this was only a proposal, if it went ahead it would have substantial consequences for kitchen staff in the public sector care homes. Less skilled kitchen staff than those currently employed would be required for food provision.

### 3.3 Overall approach to implementing the programme

During the scoping phase of the FFLBC programme, lead staff consulted widely across the adult social care sector to understand the scope for food focused work in care homes. At an early stage this led to orientating the initiative towards wider quality of life issues rather than more narrow food, diet and nutrition concerns:

> We realised at an early point that our narrative should focus on the wellbeing of older people rather than primarily on food. Food is a route to social and environmental benefits. [JH1]

Following the test and learn approach, the team also agreed the model for engagement with care homes. The role of FFLBC was primarily to offer advice, help project plan, support to coordinate specific activities, create training opportunities, and to provide small funds for activities.

> I would say it's been more of a gentle push, in terms of trying to provide external encouragement for things that are happening fairly regularly. When activities have been planned, then very much a kind of coordination of those activities, essentially project planning, so if there's a growing activity, then making sure that the people who are supposed to be at that activity at that time are there, so if it's the local school, for example, co-ordinating that. In an ideal world we would like such activities to become self-sustaining, but this presents a number of challenges. [JH2]

The team also sought to scale the ambitions for the whole settings approach given the constraints of time, resources and the co-production model:

> The original hope was that we would achieve something approaching a whole settings approach for Royston Court whereby food was used to improve care in a variety of ways, across the different elements of the framework…I'm not sure that food, as a whole, is now seen a very different light to how it was before and the potential for food based activities to really be used to enhance the quality of people’s lives in care homes is necessarily there in everything that they do. That said, I'm not sure that was actually an expectation over two years, it was probably more of an idealistic thing. [JH]

The new manager delegated the main aspects on engagement with the programme to the depute. A key reflection was that the engagement of staff over the course of the programme was a major consideration:

> The main challenge is keeping people engaged and keeping people motivated to carry on and keep it going. You need to have staff who are keen and willing because, on top of their normal job, it is something else for them to: another piece of work if you like to take on. So, unless they’re motivated, engaged and can see what it’s all about then that’s quite a challenge. [DP]
Over the fourteen-month programme period, the FFLBC lead estimated that the programme involved his time for 1.5 days per month in the first four months, and about half a day thereafter, although these overall figures fluctuated considerably. Work to set up the garden space and plant the orchard involved an external design consultant and a conservation agency that coordinated a group of volunteers. Additional FFLBC staff inputs went in to developing and delivering training for care staff in social and therapeutic cooking activities.

3.4 Food quality and the dining environment
Prior to the Better Care programme, Food for Life had worked with care homes to support them to obtain Served Here awards. At the start of the programme Royston Court were successful in obtaining the silver award. This provided an opportunity to review the fresh fruit and vegetable items supplied under the terms of the contract with the existing supplier, and to identify local producers. The award also led to efforts to consult with residents, to focus on improving the dining areas, and to make provision for dementia friendly dining. The head cook described the ethos at the home behind this:

I think food is seen as such a basic thing that it’s taken for granted in that respect. I mean we would class a dining experience as a good food activity whereas for so many people, it’s just another meal. We’ve worked hard around the whole mealtime experience to make it as good as possible in terms of dining environment and the equipment, and the décor. The mealtime experience is a much bigger picture than just a meal. [CK]

The FFLBC team lead felt that the silver award was a good achievement given the wider operating environment of the care home.

[The head cook] is using all of the requirements of the award to prepare meals freshly for the residents, and I think that’s an achievement. I think it’s probably in line with expectations: a silver Food for Life Served Here was all that we were ever expecting to achieve because there are barriers to gold which are above and beyond the site. [JH]

The Dietetic and Catering Advisor’s review of the expenditure on food and drink showed that in financial year 2018-19, the costs were higher than other care homes, but this was attributable to the high level of resident dietary needs at the home. The MUST scores showed that needs had increased markedly in the early months of the start of the care home. These stabilised over the course of the programme period, largely as a consequence of better monitoring and the settling in of provision at the care home. Although there were some staffing difficulties in the kitchen over the course of the FFLBC programme, the dietetic and catering advisor, depute manager and head cook worked closely to maintain the quality of meals in the home. The dietetic and catering advisor believed that a great benefit of the silver award was in recognition of the work of the kitchen staff:

The Food for Life Silver Award has been a huge morale booster for the kitchen staff. Quite often, kitchen staff have kind of been left out of the care homes, they’re left to get on with it and they quite often feel a bit isolated. So this has been a really good project to bring them into the care home a bit more if you like and make them feel more involved too. So that’s been really valuable. [EN]

In the latter stages of the programme period, the staff team had re-introduced a forum with residents to discuss menus in the home. Initially the FFLBC team looked at the scope for reducing the use of oral nutritional supplements, products that are costly to the health and social care system. However, within the period of the programme delivery this area was not pursued following initial scoping.
3.5 Orchard planting, gardening and growing activities
As a newly built establishment, Royston Court had a large open space and very little planting at the beginning of the programme. For Food for Life, the idea of having food growing areas fitted well with the whole settings approach originally developed in schools.

The purpose of the vegetable patches was to really involve residents in growing, residents who had an interest at least and were able to involve them in the whole growing process and using the veg that we’ve grown in the care home menus. So, the residents could say, ‘I grew that carrot that you’re sitting eating your dinner’. [EN]

The programme team also hoped that the growing space, and specifically the orchard, might open up part of the care home grounds as a community space. The act of becoming involved in shaping the external environment fitted well with the aspiration to involve residents in decision-making in the care home. The planting of the orchard was felt to be a practical option from the perspective of the relatively low maintenance required. It was also an activity that suited the interests of volunteers wanting to engage on a one-off occasion. During the planting residents were asked if they would like to choose a type of fruit tree that they would like to help plant. At this point, one of the residents—who had lived in the area since childhood—told the staff that she was particularly proud because historically there had been orchards in the area, and she felt they were helping to re-establish fruit trees for the neighbourhood.

3.6 Intergenerational activities
The FFLBC team and Royston Court approached the local nursery and primary school to take part in outdoor gardening events at the care home. The head teacher felt that this opportunity fitted well with the interests at the school:

We recognised that many of our children don’t have much contact with older people: 40% of our children have English as an additional language, their parents haven’t been in the city very long and they don’t have a wider family living nearby. [HT]

The head teacher found that the visits went very well from the perspective of the school.

[Working with the care home] was new for us, we wanted to see how our children would react. The children helped prepare the garden at the care home. You could see it the residents really enjoyed them even if they couldn’t actually take part. To start it was more a matter of the nursery staff and children and care home staff and residents being alongside each other, as two separate groups. But after a bit [the children] have got much more confident around the older people.

It’s been amazing to see how some of the children have behaved. The younger ones – 3-4 year olds – just seem to know that the residents need a bit of looking after. When the children started singing one of the residents became very vocal and clapped loudly. One of the children went over to her and patted her hand gently to let her know gently to calm down. [HT]

A member of the care staff felt that the activities went well for residents. They were out of the ordinary experiences for the residents. The activities also caused staff to reflect on how to support residents to do more outdoor activities:

Twelve children came to help dig big beds for the planting. After some hesitation, the older people were encouraged to interact. Planting activities were well received, they helped bring back memories of doing similar things. One thing we talked about was the issue of the cold weather and how we help residents to do things outside more often. [TN]

Some additional consequences of the intergenerational work included feedback from the care staff that they were more likely to engage with external parties, such as schools and volunteer
agencies, in future. The visits were popular with residents and could be adapted to be in-doors on occasions when the weather was not good. Equally the head teacher strongly supported maintaining the connection.

The link happened very easily. The care home have been really accommodating. We’ve found we can just pop along almost as often as we want. I would say is has been very practical from our point of view. It’s easy for us. [HT]

3.7 Community activity visit: botanic gardens

With the support of FFLBC, Royston Court and the local school undertook a visit to the Edinburgh Botanic Gardens to take part in an activity session led by the Garden staff. The group comprised four Year 6 primary school children and three care home residents. School and care home staff reported that the visit was well planned and succeeded in bringing young and old participants more closely together.

The visit was well organised. They started with an ice-breaker exercise matching children to residents using envelopes with contents to talk about. Then they went on to do a plant potting up exercise, picking vegetables and making a soup. MV is a family person and likes children, but did become a bit distressed at one point. Later she settled down after a walk. MX really enjoyed activities and talked about it a lot afterwards. CY also enjoyed it, especially the soup. There’s a huge benefit from this sort of activity and for doing more in the future. [RG]

The activity was led by experienced staff [who had worked] with other groups, like people with learning difficulties, people with autism. The intergenerational work was new them, but they were able to use their learning from other groups. [HT]

My eyes were really opened. If the activity is run well and thoughtfully and in a considered way, then you can run an activity that does join people up and brings them together without feeling like it’s been contrived to do that. Just by keeping it quite simple and quite sensual with the touch and smell and feel of something and then talking about that, because I think most people can relate to it. [JH]

Interviewees recommended that these groups worked best when there was careful planning with respect to timings, transport and advance information. The head teacher felt that safeguarding issues tended to be well addressed as a consideration when working with older people in care homes:

A key issue is trust. We need to be sure that the visits are safe. Obviously all their staff have been checked to work with vulnerable people. The other thing is that the residents are accompanied by staff, and usually in the care home rather than out in the community. So we don’t have concerns that the children will meet them elsewhere in the community. It sounds mean but we have to think about these things. [HT]

The activities were well supported by parents. One consideration was the complexity of organising joint community visits. Further activities had been planned with the Botanic Gardens, but had to be cancelled due to clashes with other events.

3.8 Cooking and social food activities

The main programme activity with respect to cooking was the linked to food growing. The head cook worked with residents to harvest vegetables from the garden plots at the care home and prepared a soup. This was well received by residents and the cook felt that it was an activity that would be straightforward to repeat with other produce from the growing areas. However, it did require spontaneous action in order to make the occasion work:
We often find we don’t have time to plan. It was quite rush to harvest the produce. I tried to make it all an experience for them by bringing some of the residents together to help make a home grown soup. It was all a bit of rush but it made me want to do more of this sort of thing, to do more consultations, get more engaged and do more directly with residents from the kitchen. [CK]

Other planned cookery sessions did not go ahead. A baking session was offered to 40 residents, but only two expressed an interest. Two staff received training by FFLBC on running cookery sessions and the care home was given equipment, including an induction hob, through the programme. However, staff had some concerns around the appropriateness of running cooking sessions within their setting, and how it would work from a practical perspective to have cooking operations within wings of the building. One member of staff felt that problems running these activities could be anticipated given other pressures in the care home:

It’s the work pressures. I know that there are staff who would love to do activities like that, but they just don’t have the time. There’s so much paperwork to be completed on a daily basis, there’s all the care element of looking after frail, vulnerable people with dementia who sometimes need one-to-one support. You’ve got people at end of life care, people in palliative care. So just the demands of their daily job just doesn’t really allow them to do things that they would really like to do. Which is a shame because, in terms of their own development as well, we’re not able to develop staff as much as we would like because of these issues, so it’s more the pressures of work rather than not wanting to do things. [EN]

3.9 Other social activities at the care home
Over the course of the programme, care home staff ran a number of social activities including bingo, live singing entertainment and a bar within the home. Staff organised a boat trip, a zoo visit, and a visit to the home by a Shetland pony. These followed similar activities in the past and had previously received good feedback from the residents. The team does not have a dedicated social activities coordinator, so general care staff pick up the role.

3.10 Links to wider programme work
The work at Royston Court went alongside engagement by the FFLBC team with other care homes – both public and private sector – in the Edinburgh area. Managers from a leading private sector care chain considered taking up the FFL Served Here award, but decided that it was not a scheme that they could take forward. The FFLBC team felt that the most productive approach was to engage them on specific social and therapeutic activities that they were willing to take forward: “they slightly cherry picked from the care home framework [but] it didn’t feel like it mattered because it’s the entry point of a journey towards the whole settings approach….It would be kind of hard for us to insist that it’s all or nothing from the outset.”

The FFLBC team continued to work closely with the Dietetic and Catering Quality officer for public sector homes in Edinburgh. There was ongoing work with staff and volunteers at Inchview, a care home that FFL had initially developed links with in 2014. FFLBC offered a smoothie maker kit to Inchview and other care homes in the city. Smoothies were found to be a good way to provide energy dense nutrition and fresh fruit whilst being aware of potential problems of the high sugar content for diabetic patients. During the programme period, the Soil Association had submitted care homes whole settings proposal to Edinburgh Health and Social Care Partnership, however the bid was not successful.
4. Outcome evaluation findings for the programme

4.1 Engagement and impacts of the programme

The following table summarises the findings from the assessments of staff with regard to the engagement and impacts of programme-linked activities for residents. The results show that there were positive impacts of FFLBC activities for social interactions, social wellbeing, and mood. Self-evidently there were stronger reported impacts for enjoyment of meals and mealtimes, diet and nutrition for those activities most closely linked to eating.

Of the FFLBC social and therapeutic activities, intergenerational events were those most widely taken up by residents. This reflects the findings from the process evaluation interviews. Eating in the social dining areas is an important part of the daily routine of the care home. Staff reported that, for a majority of the residents, that social mealtimes were an important part of the quality of life for those regularly taking part. Across all measures, the instances where staff did not report positive impacts were often because they were uncertain or the overall picture was complex.

It is notable that, at the point of the assessment exercise in November 2018, a number of residents had recently come to live at the care home subsequent to the FFLBC activities or were unable to take part because they were confined to their beds with very poor health. The table also shows that substantial proportions of residents did not take part in FFLBC activities. Interviews with staff captured a number of reasons of which the leading ones were active decisions not to participate, and poor physical or mental health or capacity. Overall, it appears that high levels of vulnerability and need made it challenging for around half the residents to engage in social activities. However, it is a complex picture given that ability and willingness to engage should be put alongside the support available to enable engagement.

4.2 Qualitative findings on resident experiences of FFLBC activities

The following accounts show how residents benefited from activities linked to FFLBC activities. Staff were best able to identify benefits linked to the gardening and activities and visits from school and nursery children. The experiences illustrate a diverse range of themes such as improvements in mood, feelings of connectedness to others, feeling validated and supporting personal identity, involvement and belonging in the care home, fun, and new experiences. A number of the accounts show the connections between different aspects of life in the care home, for example in terms of the links between gardening and social dining activities or family visits and relationships with care staff.

Bill used to have an allotment and was always a keen gardener. He really enjoyed pulling up carrots and cutting greens from the raised beds. He said it brought back good memories. The cook used the veg to make a soup. He really enjoyed it…Bill is quite a sociable person. He engages being with other people in the dining room, but he interacts more with the care staff than the residents. [BR02]

For the gardening days, Enid came outside to see the visit from the nursery children. She was on the side lines a bit. She’s quite sort of reserved and she didn’t want to directly take part in the sowing and planting activities. She’s proud of her hands and doesn’t want to get them messy or dirty. It’s afterwards when we noticed the difference, she really came out of herself and was much more talkative than usual. Just seeing the children at the care home lifted her spirits. [MO04]
Brenda spends most of her time in her room watching TV. She mostly eats meals by herself in her own room. She’s quite inward and gets low. She really liked meeting the children. I think it was a very different experience from normal for her. [MM06]

Iris is generally very happy and sociable. So she loved it when the children come. She likes to talk to the children and sing them songs. It was a lot of fun outside when the children came. Iris got interested in the plants and their names, some which she’d never heard of before. She tried a soup made from the produce and hadn’t tasted coriander before. [MB05]

Sheila came from a care home nearby that shut before opening up Royston Court. She has found it difficult - coming to a [new] home. She has mood swings and can be very unsettled. She took part in fruit tree planting activity and the naming of the trees. It wasn’t planned. She saw it taking pace then wanted to get out and take part. Sheila also likes to go to the kitchen and find out what the cooks are making on the day. It's little things like that that help her feel more settled here. [CD03]

Martin’s wife recently died and he hasn’t been too good. We’ve been trying to encourage him to take part in social activities, but he can be quite distant. He’s originally from Donegal and a native Gaelic speaker. It happens that I also speak Gaelic. I found out he grew up on a small farm, growing potatoes and selling them to the local shops. Martin helped plant out and look after the potatoes with the children’s visits. His family were thrilled to see him involved in something social that helped him remember his Irish culture. [HF11]
Table 1: Resident engagement and impacts arising from FFLBC activities

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<tr>
<th>Activity</th>
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<th>b</th>
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<th>d</th>
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<th>Rating of observed impact*</th>
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<td>Positive impact on</td>
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<td>social interactions N %</td>
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<td>wellbeing N %</td>
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<td>Positive impact on mood N %</td>
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<td>nutrition N %</td>
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<td>Social and therapeutic gardening activities</td>
<td>56</td>
<td>3</td>
<td>4</td>
<td>26</td>
<td>23</td>
<td>13 (57%)</td>
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<td>56</td>
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<td>35</td>
<td>14</td>
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<td></td>
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<td>24</td>
<td>26</td>
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<td></td>
<td>56</td>
<td>3</td>
<td>4</td>
<td>46</td>
<td>3</td>
<td>3 (100%)</td>
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<td>Eating in social dining area on majority of</td>
<td>56</td>
<td>3</td>
<td>2</td>
<td>18</td>
<td>33</td>
<td>27 (82%)</td>
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<td>days</td>
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<td>3</td>
<td>2</td>
<td>20</td>
<td>31</td>
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<td>Other social activities organised by care</td>
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Notes * Main reason for not giving a rating of a positive impact was ‘don’t know / not observed’
While many of the residents benefited from activities linked to the programme, it was evident from the care staff that the activities were not well suited to the needs or interests of many residents. The following extracts give indications of the gaps between the aspirations of the programme and the circumstances of some residents.

Marge becomes distressed especially when there is something out of the ordinary. She has a set routine and wants to go for short walks a lot. She does interact with other residents and staff but it’s often on her terms. She finds it difficult to take part in social activities. Marge becomes less stressed when her family are present, but they are can’t visit very often. [MM13]

[Gill’s] health has declined recently. Nowadays she is not a good eater, she has dementia, which has affected her appetite and she forgets to eat. She has watched the garden activities and seems to enjoy the visits by the children. [KM10]

He is a very private person and prefers to stay in his room. He does not have conversations with other residents, and only limited conversation with staff. His daughter says he was like this before he came to Royston. He eats very simple food in his room and rarely goes out. [NO07]

Dorothy needs full assistance. Her speech not good. She is non-verbal, but will hold your hand. She can get very distressed and needs assistance at all mealtimes. She doesn’t engage when there are social activities, but music can help her relax and that’s very important for her. [JW04]

She’s a very keen watcher of the TV and really loves cookery shows. Her favourite treat is to get a KFC meal. She often likes to go outside and walk. Emily enjoys the sing-alongs. But otherwise she needs a lot of encouragement to get involved and doesn’t like anything like gardening, cooking or craft. [IG05]

5. Discussion

5.1 Discussion of key processes of change and challenges to the programme

Over a fourteen-month period, the Food for Life Better Care team collaborated with staff and residents at Royston Court to focus on food and food-related activities as a social experience and a bridge to the surrounding community. Food for Life Better Care sought a comprehensive approach, in that the programme was informed by a whole settings approach to take into account multiple aspects of food. The team adopted a ‘test and learn’ approach to the programme. This involved consulting with residents, care home staff and others on types of activities to run, testing them out, and reflecting upon the learning. The limited time period and constraints of the wider context meant that the team set modest goals and were mindful of the need to embed work that might be sustainable beyond the programme funding period. There were a wide range of benefits linked to the programme. Notably, care home staff were confidently able to identify positive impacts on social connections, social wellbeing, mood, diet and mealtime experiences for the majority of participants in FFLBC linked activities.

The programme achieved some successes in supporting the care home to enhance the quality of food provision. A key benefit of the Silver Food for Life Served Here Award was for the recognition it gave to the kitchen staff in the care home. This helped communicate the additional value that on-site kitchen staff could bring to the quality of life for residents through, for example, rapid adjustments to meals or personal dialogue between cooks and residents about the
ingredients and preparation of meals. A focus on meals aligned well with the care home’s work to raise staff awareness and responsiveness towards malnutrition indicators. Nevertheless, there were limits of what could be achieved. Financial pressures on catering budgets placed constraints on menus beyond the normal standards for the care home group in Edinburgh. Despite a supportive policy context (Procurement Reform (Scotland) Act 2014; Public Bodies Act, 2014), local actors expressed concerns about the wider awareness and understanding of the social value of tailored procurement processes.

The intergenerational activities were new experiences for both the care home and local primary school. They matched the core values of both institutions and staff reported them to be relatively straightforward to set up and run over time. These activities were popular with residents and included residents with a wide range of abilities and interests. According to staff, the feedback from children was very positive. These impacts were supported by accounts of residents about making rich memories; novel, fun and exciting experiences; connections to people in new ways; and engaging in meaningful activities and making links to the local area.

The act of becoming involved in shaping the external environment fitted well with the aspiration to involve residents in decision-making in the care home. The gardening and growing activities helped create new volunteer and community links that are likely to be sustainable beyond the period of programme support. The new growing areas and orchard established a longer-term legacy for the programme. Efforts to promote the use of the outdoor space and engage the wider community clearly aligned well with the Health and Social Care Standards (2018).

While a number of different FFLBC activities took place at the care home, the connection and integration between activities was not necessarily strong in all cases. As a consequence, staff and resident awareness of the overall goals of the programme was not widespread, although a majority were familiar with the programme activities. Relatives were slow to engage with the programme, a matter that limited the extent to which the initiative could fully reflect the whole settings approach envisaged.

The vulnerability and high support needs of residents appeared to restrict opportunities to participate. This is likely to be an issue for care homes more widely as support needs increase, and adult social care provision is compelled to focus on core statutory duties. Notably, as a Care Inspectorate report (2017) found, many care homes are struggling to meaningfully engage people with dementia with their environment and to integrate with their community.

Some activities, notably linked to cooking, did not attract strong interest from residents. This might have mirrored the low interest or priority that staff felt able to give to practical cooking sessions. It could also relate to the overall culture of care in which activity planning was not a priority role for a specific member of staff. The absence of a dedicated activities coordinator, or staff with equivalent experience, may have restricted the ability of the care home to engage and develop activities.
There was pressure on care home staff workloads which affected the priority that staff could give to FFLBC activities. Additional priorities to improve basic care planning and implement staff development in this area restricted opportunities to take up and implement FFLBC training activities. This reflects wider research on the restricted ‘headroom’ that staff have to engage with innovative practices (Goodman et al., 2017).

5.2 Limitations
There are a number of limitations to this study. The research did not record the longer-term consequences of the FFLBC work at Royston court but, rather, focused on the short-term processes of implementation and the immediate impacts. We did not adopt a structured approach to gathering the perspectives of residents directly. However, the use of the in depth interviews and a proxy tool for gathering staff perspectives helped us record staff perceptions about all the residents at the care home towards the end of the programme. This is in contrast to other studies that only capture the consequences for those most involved. Although the study reports on subjective perceptions, we were able to triangulate data sources, from multiple staff with respect to the same activities and residents, and with programme delivery records. An initial plan for the evaluation had been to use standardised self-report questionnaires with residents, however following feedback from a Social Care Research Ethics Committee, we decided not to proceed with this approach given the high level of vulnerability and capacity to consent by some of the residents.

5.3 Implications for practice and policy
Social and therapeutic food activities would have had a greater effect if all members of staff responsible for care of older people (not just those given the role of coordinating activities) understand the importance and benefits of meaningful activity for residents and for them in their role as carers.

Food-related intergenerational activities can greatly benefit from external facilitation by skilled practitioners. However, this study showed that care and school staff had the basic knowledge, skills and interest to develop and deliver sessions that were feasible in the context of other priorities, safe and meaningful for participants.

In this case, the initiative did not require a high level of resources to promote food and wellbeing related activities in a care home setting. Light touch advice and guidance from a specialist programme team helped avoid setting up unsustainable expectations and succeeded in mobilising the interests and skills of care home staff.

Specialist support to advise on the reform of procurement practices in public sector catering is well received by staff with a procurement remit.

It is relatively straightforward for care homes to undertake activities that support a whole settings approach to food in care homes. Under current conditions, pressures in the sector imply that strong leadership and vision is needed within the sector to produce an exemplary model of best practice in whole settings work.
Current commissioning models place considerable constraints on food culture, social and therapeutic activities in care homes. Moves to localise and prioritise social value in commissioning would enable residents and staff teams to have greater autonomy and flexibility in how they influence work in this area.

While the adult health and social care residential sector has improved its guidance, there remains a need to prioritise the social role of food and to avoid unanticipated negative consequences of a medicalised approach to diet and nutrition, such as the unnecessary use of oral nutritional supplements.

6. Conclusion

This report is one part of a wider set of research on the role of the Food for Life Better Care work with care homes in England and Scotland. The scheme embodied ambitious aspirations to improve the place of food and food related activities for older people in care settings. This is a highly challenging sector to work in, but with an ageing population, better recognition of the voice of older people, and new visions about ageing better, the goals of FFLBC have been a timely. The work at Royston Court illustrates practical actions that can be taken under realistic circumstances, and with view to the longer term embedding of learning. The evidence indicates that the whole-setting approach to food in care homes has beneficial impacts and is likely to be transferable to other similar settings.

7. References

Main sources


**Additional references**

Age UK Malnutrition Task Force http://www.malnutritiontaskforce.org.uk/prevention-programme/


Appendix 1. Interview schedule for staff and volunteers

Thank you for agreeing to take part in this interview.

1. Let’s start with your background and the role you play in the care home with regards to food.
2. Can you tell me what is it like being involved in a whole setting approach to food in the care home? Prompt: what does a whole setting approach mean to you (paraphrase if not clear).
3. What’s good about working on a whole setting approach to food?
4. Can you give me an example of a positive experience you have had in implementing the whole setting approach to food?
5. What’s not so good about implementing a whole setting approach to food here?
6. Can you give me an example of a negative experience?
7. What do you think are the main problems with the whole setting approach to food from the point of view of staff?
8. How does carrying out a whole setting approach to food here compare to other places you have worked or are working?

Thank you.

Appendix 2. Resident Experiences of Food for Life Better Care: proxy tool

ID code: ____________

1. About how long have you known the Resident? ____________

2. About how long has s/he been living in the care home? ____________

3. Do you know if the Resident has taken part in recent therapeutic food and growing activities? We’re focusing on activities led by the Food for Life Better Care team such as gardening outdoors, intergenerational activities, lunch events, and food quality work happening in the kitchen.

4. What would you say they got out of these activities?

5. If they have NOT taken part in these activities, do you know the reasons why?

6. Overall, what do you think the impact of the FFL BC activities have been?

<table>
<thead>
<tr>
<th></th>
<th>Negative impact</th>
<th>No change</th>
<th>Positive impact</th>
<th>Very positive impact</th>
<th>Don’t know</th>
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</thead>
<tbody>
<tr>
<td>Socialising with other people</td>
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<tr>
<td>Mood</td>
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<td>Mental wellbeing</td>
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<td>Diet and nutrition</td>
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<tr>
<td>Enjoyment of meals &amp; eating</td>
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## Appendix 3. Logic Model Care Homes

<table>
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<tr>
<th>Inputs</th>
<th>Example Activities and Outputs</th>
<th>Short</th>
<th>Medium</th>
<th>Long</th>
</tr>
</thead>
</table>
| Big Lottery Funding | **Activities** | **Participation** | **Outcomes** | **Residents and their families:**
| NHS trust/CCG/Public Health Authority | - Guidance and support for settings to achieve FH, Served Here and embed good food culture. | - Care Settings staff participate in making changes to improve food culture. | - Increase in number of settings working towards and achieving the FH, Served Here and embed good food culture. | - Reduced isolation, improved well-being, and improved nutrition/hydration for older people. |
| Sector/Local providers of care (local authority) support through funding initiatives | - Training/workshops/seminars: e.g., using food therapeutically in settings such as food growing and hen keeping; whole setting approach for senior managers; Care to Cook; reducing waste; communal dining. | - Participation from CCGs, Age UK, health and social care leaders, and wider stakeholders in making strategic changes to improve food culture. | - Increased capacity and capability of care setting staff through knowledge, skills and confidence (Key 4, Key 4a and 4b). | - Increased satisfaction of family/friends of residents with care provision. |
| FSL, Co-Developed Framework for care settings and FSL, Best Care Development, work including case studies | - Participation from older people, friends and family in development of activities in care settings. | - Participation from health and social care teams and wider related workforce in supporting changes to improve food culture. | - Greater awareness amongst care workers of risk factors that may lead to malnutrition in older people and improved monitoring of malnutrition. | - Care settings take a whole setting approach to food, e.g., whole setting food policy, introducing therapeutic food growing and improving meal times (2b and 2c). |
| Ethnographic Research findings, FSL staff expertise, Expert partner organisations | - Participation from health and social care teams and wider related workforce in supporting changes to improve food culture. | - Participation in Intergenerational linking from pupils, Head Teachers, Governors, School staff, Age UK, Volunteers, care setting staff. | - Improvements in indicators of well-being and nutrition for residents of care settings (2a) e.g., grip strength, ability to stand from chair unaided. | - Local and regional: Enhanced local food economy through procurement practices. |
| FSL central support | - Support for schools and care settings to work together on Intergenerational linking projects. | - Increased confidence in schools and care settings in working together (Key 4). | - Children and older people access knowledge, skills and opportunities for social interaction through Intergenerational participation and learning. | - Increased confidence in schools and care settings that demonstrated potential for food to influence health, wellbeing, sustainability, health and social care finances. |
| FLSM award scheme | - Strong existing networks | | | |