A Whole Setting Approach to Food in Care Homes

A case study evaluation of the Food for Life Better Care programme in Calderdale

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<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.4 Schools</td>
<td>21</td>
</tr>
<tr>
<td>6.5 Care home</td>
<td>22</td>
</tr>
<tr>
<td>7. Discussion</td>
<td>23</td>
</tr>
<tr>
<td>7.1 Summary of main findings</td>
<td>23</td>
</tr>
<tr>
<td>7.2 Challenges associated with implementation of the programme</td>
<td>24</td>
</tr>
<tr>
<td>7.3 Limitations of the evaluation</td>
<td>24</td>
</tr>
<tr>
<td>7.4 Implications for practice and policy</td>
<td>25</td>
</tr>
<tr>
<td>8. Conclusion</td>
<td>25</td>
</tr>
<tr>
<td>9. References</td>
<td>26</td>
</tr>
<tr>
<td>9.1 Main sources</td>
<td>26</td>
</tr>
<tr>
<td>9.2 Additional sources</td>
<td>30</td>
</tr>
<tr>
<td>Appendix 1. Interview schedule for staff and volunteers</td>
<td>31</td>
</tr>
<tr>
<td>Appendix 2. Resident Experiences of Food for Life Better Care: proxy tool</td>
<td>31</td>
</tr>
<tr>
<td>Appendix 3. Logic Model Care Homes</td>
<td>32</td>
</tr>
</tbody>
</table>
Executive Summary

Malnutrition, social isolation and loneliness are major personal concerns and public health issues for older people in care homes.

In November 2017, the Food for Life Better Care team collaborated with staff and residents at Summerfield House Care and Nursing Home (SFH), a large care home in Calderdale, to test a whole settings approach (WSA) to food using a co-design test-and-learn approach. The WSA focused on food and food-related activities as a social experience and as a bridge to the surrounding community.

The University of the West of England (UWE) evaluated the impacts around this novel approach to food in the care setting as part of a case study to the wider programme evaluation in two other localities – Edinburgh and Leicester City/Leicestershire.

As part of the programme delivery, a series of trainings, workshops, gardening and growing and food-related activities were carried out to promote leadership for a health-promoting setting; establish community and partnerships; improve catering quality, enhance resident food experience; and promote therapeutic food activity.

Care home staff perceived the programme to have a positive impact on the social (87%, n= 23), affective (63%, n= 19) and nutritional (50% n= 15) wellbeing of selected residents. Care staff reported testimonies from resident’s relatives about their satisfaction of care because of the programme. School children demonstrated acts of empathy and friendships through the intergenerational links of the programme. The care home received Bronze Food for Life Served Here Award for the recognition it gave to the kitchen staff in the care home. Through this award scheme, the care home had improved its food quality, saved cost on food and reduced its plate waste.

Staff confidence and perceived value of the programme and resident capacity, mood and personality were major determinants of the successful delivery of the programme in the care setting.

Challenges associated with implementation of the programme included limited monetary budgets that determined the number and scope of activities carried out. There was lack of dedicated space for carrying out indoor activities within the care home. Care staff could not be available for some training sessions of the programme because of their shift patterns. The nature of the built infrastructure of the care home did not permit some aspects of resident dining experience to be improved and gardening activities to run smoothly.

Our evaluation findings suggest that residents social, affective and nutritional well-being are likely to improve through the FFL BC whole settings approach to food when the following contextual environment is provided:

- Care home leadership and management include clear plans and roles on food-related activities in the tasks and workload of care staff
• There is available space dedicated for programme activities; and the built environment of the care home can allow smooth running of programme activities
• Care setting has adequate budget available for procuring BC programme resources
• Staff turn-over is low, and staff shift patterns enable care staff to be available to take part in programme activities
• There is a strong food ethos in the care home that prioritises food-related activities

The work at SFH showcases the implementation of a whole settings approach to food in the context of a large care home setting where staff buy-in is essential to overall programme delivery. The WSA has perceived beneficial impacts to staff, relatives and the wider local community and is likely to be transferable to other care settings.
1. Introduction

In March 2017, the Soil Association’s 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 three areas of Edinburgh, Calderdale, and Leicester city/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 Calderdale based programme has been to work with one care home, Summerfield House (SFH), over a twelve-month period. The focus of this report is on the evaluation of FFL BC activities in SFH.

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 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 psychosocial 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 fewer 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).

Living in care homes is one of the risk factors to loneliness among older people (Savikko et al., 2005; Age, 2014), and 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 contacts, 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 (Arslantas 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 (Zehhauser et al., 2014). Loneliness leads to the development of dementia (Kuiper et al., 2015); incidence of cardiovascular diseases (Thurston and Kubzansky, 2009) and a significant risk factor to mortality (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

In England, the present government has an overall policy objective emphasising the need to promote and maintain independence wherever necessary via support in the community or rehabilitation. The Care Act 2014 is seen as a major reform in care and support in England and enables those in need of care to manage their care and support. Key criteria set in the Act includes when support needs to be provided by local authorities for those in need of care and support. It outlines changes to the eligibility assessment by local authorities for those who require care and support. This involves encouraging those in need of support to consider their desired physical or emotional well-being outcomes. The Act grants rights for carers on an equal plane to those who they care for; and carers must also be assessed for support to meet their needs in relation to care. Of major relevance about this Act to the care home sector is the greater regulation and tougher sanctions for care home providers who fail to meet certain quality standards of care (The Care Act, 2014). The Care Quality Commission is tasked with such regulation.

Through, the Health and Social Care Act 2008, the Care Quality Commission (CQC) is designated as the independent regulator of health and adult social care in England. In addition to primary care and hospitals, the CQC ensures that care homes, as part of social care services in England, are providing effective, high-quality, safe and compassionate services to residents (Care Quality Commission, 2019).

There are about 329,000 people living in care homes in England and this figure is expected to rise in the coming years. The average age of care home residents is 85 years and the average life expectancy in care is 462 days. Most care home residents live with complex health conditions including dementia, musculoskeletal problems and stroke (National Institute for Health Research 2017; Wittenberg and Hu 2015).

Most care home providers in England are from the private sector. Social care in England is means-tested and not free at the point of use. Local authorities assess people for eligibility to
support with funding. Local authority fund more than half of the residents in care homes in England (The King’s Fund, 2018).

The central government provides revenue to councils to fund their social care. This is in addition to locally-generated funds including council tax and other funding streams such as the Better Care Fund and Improved Better Care Fund. However, there is uncertainty in the funding from these streams from 2020 (Jarret, 2018). As a result, Directors of Adult Social Services and their councils are considering challenging decisions such as closure of some care homes (ADASS, 2019). Closure of care homes negatively affect the lives of individuals in need of these services, their families and the workforce in this sector. For example, within the past six months, closure of care home and home care providers have affected more than 7,000 individuals. This also means that, significant pressures will be put on the NHS, such as increased admission rates and delayed discharge rates for people into social care services (ADASS, 2019). Such delayed discharges have a cost burden of over £500 million every minute to the NHS (Age UK, 2018).

Person-centred care is an important principle in delivering care in care homes. Thus, care provided to care home residents needs to consider the person’s unique preferences, abilities, qualities, needs and interests. For people with dementia, the aim of care is to see them as individuals, rather than focusing on their cognitive impairments (Alzheimer’s Society, 2019). The National Institute for Health and Care Excellence (NICE) encourages health and social care providers, including care homes, to ensure care is person-centred and that the person cared for receives support that promotes respect and enhances trust and dignity (NICE, 2013).

“Every breach of human dignity not only affects the individual victim, but also society as a whole, by raising the question of how we choose to live (and die) and relate to each other. It thereby calls into question the state’s role in protecting our dignity” (Dupré, 2011)

For some time now, meals and mealtimes have been the ‘highlight of the day’ for many residents in care homes (Commission for Social Care Inspection, 2006) and several actions have been recommended to promote the dignity of care home residents through meals and mealtimes. For example, the Social Care Institute for Excellence (SCIE) recommends that care homes need to provide residents with choice of meals and help them with meal consumption if needed. Mealtimes go beyond eating food and includes the social dining experience and comfort in eating. The presentation of food is important in any texture or form that is required by residents to enhance mealtime experience. Residents must be given enough time to eat their meals. Care staff must encourage socialising during mealtimes; but also respect the preferences of those who wish to eat in private. There needs to be adequate staff during mealtimes to assist residents with their meals when needed and care staff need to have access to training on meals and mealtimes. Care homes must use or develop volunteer schemes that can assist residents during mealtimes. Food in care homes need to be of good quality and where possible, locally sourced and sustainable to ensure best practice in food procurement (SCIE, 2013).

The CQC ensures that care home residents are provided with the required nutrition and hydration needs to sustain life, promote good health and minimise the risks of malnutrition and dehydration. Residents’ religious and cultural preferences of meals and mealtimes must also be
considered in food services in care homes (Care Quality Commission, 2015; Alzheimer’s Society, 2019).

It is important to provide care home residents with the opportunity to engage in meaningful activities that maintain and improve wellbeing. Care staff should encourage residents to actively choose and shape activities which they find meaningful (NICE, 2013). NICE (2013) also recommends that opportunities should be provided for families, friends and carers to be involved where possible and by the wish of residents, in planning and carrying out residents’ activities. This ensures that activities are meaningful and can develop and maintain relationships.

The Alzheimer’s Society (2019) highlights the need for residents to spend quality time outdoors. They suggest that some residents with dementia who reside in upper floors of care home buildings cannot easily access outside compounds and gardens. Such residents require extra support to help them spend more time outdoors to encourage regular exercise, exposure to sunlight and fresh air to promote their wellbeing.

Identifying and promoting regular opportunities for residents to meaningfully engage in activities is essential for person-centred care and the wellbeing of care home residents. “Every experience and interaction can be seen as an opportunity for engagement. Engagement should be meaningful to, and purposeful for, the individual living with dementia. It should support interests and preferences, allow for choice and success, and recognize that even when the dementia is most severe, the person can experience joy, comfort, and meaning in life” (Fazio et al., 2018; p. S18).

Social isolation is a grave menace for older people in care homes and care home staff must recognise residents who become socially isolated (NICE 2015). Residents of care homes must be provided with the opportunity to interact with each other and develop acquaintances with fellow residents and staff through a range of social opportunities (Alzheimer’s Society, 2019).

The care team should provide opportunities for residents to establish and sustain links with their community, friends and family. They should consider developing partnerships with voluntary and community sector enterprises and services to support residents to become active and integrated within their community (NICE, 2015). The Alzheimer’s Society (2019) suggest that people with dementia should be supported to establish relationships with other people outside care homes.

Food defines the quality of a care home for residents (PG Professional and the English Community Care Association, 2006). The Commission for Social Care Inspection (2006) summarises the key points to enable a culture change in food and mealtimes in care homes as, “good leadership, staff induction and training and adequate staffing levels”.

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 whole settings approach (WSA) towards improving multiple aspects of food in educational environments. Since 2011, 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 Community Fund (formerly known as 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 (Figure 2). FFL sets these domains out as co-design training and support packages to:

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
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 Appendix 3.

Figure 2 Food for Life Better Care: Framework for a whole settings approach in care homes

1.5 Study setting
The FFLBC’s WSA was implemented in Summerfield House Care & Nursing Home (SFH) in Halifax, West Yorkshire. SFH is a privately-owned care home with residential, nursing and dementia care. It is a modern building with 107 rooms over three floors with one to two dining areas on each floor. It is situated within the Calderdale Metropolitan Borough Council. Calderdale Metropolitan Borough Council has 20 nursing homes; 61 residential homes; 25 respite care and 18 supported housing. SFH is equipped with facilities and services such as palliative care, day care, respite care, convalescent care, own GP if required and gardens for residents. The care home has 130 care staff and nurses and receives about 200 visitors per week.
At the last Care Quality Commission inspection in June 2017 the service at the home was rated Good.

1.6 Research aim and questions
This evaluation intends 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 a case study methodology and design (Yin, 2003), drawing upon multiple data sources including 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 context-mechanism-outcome (CMO) 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 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.

2.3 Eligibility, selection and recruitment of participants
All care home staff and volunteers were eligible to take part in the evaluation. 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. There was no exclusion on staff based on their level of engagement in the FFL BC programme. We also requested interviews from programme staff, volunteers and staff from partner agencies linked to the programme. Potential participants were made aware of the evaluation through the manager of the care home and FFL BC local programme manager (LPM). They were provided with an information sheet about the evaluation and given contact details to make further enquiries.
2.4 Data collection and programme documentation
The programme was monitored through capturing key aspects of its delivery. These aspects included programme engagement with agencies; programme activities and outputs and programme outcomes.
Semi-structured interviews were conducted with participants to explore their perceptions of the development, implementation, context, perceived outcomes, challenges and opportunities for the programme. Interviews with care home staff were conducted individually and lasted approximately 30 minutes. The interviews with the LPM and manager of an external social enterprise agency linked to the gardening activities (MEA) lasted for three-and-a-half hours. Care home staff interviews were conducted on the premises of the care home in a quiet location and interviews with the LPM and MEA were carried out in an arts centre.

Interviews were conducted at three different phases. The first phase of interviews was conducted at the initial stages of the programme implementation to explore care home staff and volunteer perception about the programme, potential impacts and any anticipated barriers in engagement (Appendix 1). The second phase of interviews was conducted using a proxy questionnaire tool to collect anonymised information about residents and their engagement with programme-related activities and observed outcomes from the perspective of staff (Appendix 2). Care home staff and activity coordinators were interviewed in the first and second phases. The final phase of interviews was with the LPM and MEA.

In total we conducted 14 interviews with 12 individuals. We also reviewed documents on the overall BC programme delivery narrative; garden and growing narrative document; and the Food for Life Served Here (FFLSH) data capture document. Table 1 identifies and summarises the sources of information for the evaluation.

2.5 Data recording and analysis
Qualitative data from the interviews were audio-recorded and transcribed. We analysed the data thematically using procedures proposed by Clarke and Braun (2014) with the help of the NVIVO 12 software (QSR International, 2018).

2.6 Ethical Issues
The University of the West of England’s Research Ethics Committee granted ethical approval for the evaluation (ref: HAS.17.08.004). We obtained informed consent from all participants. Participants were provided with an information sheet detailing their role in the evaluation and they were given the opportunity to clarify any information regarding the evaluation. Potential participants were given a consent form to sign to document their agreement to take part in the study if they were still 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. No participant withdrew from the evaluation. Digital data was stored securely on password-protected computer servers at UWE and were analysed only through these sources. During fieldwork, data was temporarily held on password-protected encrypted laptops, before being transferred to the main repository at UWE. The data was stored in accordance with the General Data Protection Regulation (GDPR, 2018). Pseudonyms have been used to replace real names in quotations.
### Table 1 Sources of data and their description

<table>
<thead>
<tr>
<th>Data sources</th>
<th>Role / description</th>
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<tr>
<td>Senior cook (SC)</td>
<td>Coordinating meal preparation in the care home</td>
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<tr>
<td>Clinical Lead (CL)</td>
<td>Predominantly works on the nursing floor as the nurse-in-charge providing routine clinical care for residents</td>
</tr>
<tr>
<td>Senior Care Assistant– Dementia Unit (SCAD)</td>
<td>Routine care and support for residents on the dementia floor</td>
</tr>
<tr>
<td>Care Assistant 1 – Nursing Unit (CA1)</td>
<td>Routine care and support for residents on the nursing floor</td>
</tr>
<tr>
<td>Care Assistant 2 (CA2)</td>
<td>Routine care and support for residents on all floors</td>
</tr>
<tr>
<td>Senior Care Assistant (SCA)</td>
<td>Managing care staff, ordering and administering medication, managing care plans, ordering GPs and making sure residents are safe and well</td>
</tr>
<tr>
<td>Activity Coordinators (AC1, AC2, AC3 and AC4)</td>
<td>Facilitating planned social activities among residents in the care home</td>
</tr>
<tr>
<td>Deputy Manager of Care Home (DMCH)</td>
<td>Assist manger in the overall running the care home</td>
</tr>
<tr>
<td>FFL BC Local Programme Manager (LPM)</td>
<td>FFL. BC local programme manager across Calderdale and Kirklees and registered public health nutritionist (with expertise in older people’s nutrition)</td>
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<tr>
<td>Manager of Social Enterprise linked to FFL BC WSA (MEA)</td>
<td>Working in partnership with Better Care to deliver the garden aspect of the therapeutic food project as part of the WSA</td>
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<tr>
<td>BC Narrative Document (BCNC)</td>
<td>Document containing sequential implementation of programme in the care setting</td>
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<tr>
<td>Garden and growing narrative document (GGNC)</td>
<td>Document containing process, output and outcome of gardening and growing activities</td>
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<tr>
<td>Food for Life Served Here data capture form (FFLSH DCF)</td>
<td>Data record form on process of awarding FFL SH Award to SFH</td>
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### 3. Findings: programme activities and outputs

The LPM spent two days a week within the first six months of the programme, and then one day a week for another one year, in the delivery of the programme at SFH. About forty-percent of the MEA’s time was invested in gardening and growing work at SFH, working more intensively with staff teams, residents and schools. Programme activities were delivered across the domains of the FFLBC WSA framework (see also Figure 2).

#### 3.1 Leadership for a health-promoting setting

Two Whole Settings Approach to Good Food workshops were organised in November and December 2017 in Calderdale as part of the BC programme. Care home and community care setting managers and leaders attended to find out how to implement and embed a holistic, good food culture in their settings. There were 51 attendees in total from 22 care homes in both workshops. Five staff from SFH attended one of these workshops and these were the manager, deputy manager, two cooks and one activity coordinator. Attendees at the workshop were introduced to the WSA ethos in care settings and were provided with relevant resources that could guide them to carry out a WSA to food in their care settings.
3.2 Community and partnerships

Box 1 lists the agencies and partners who took part in the delivery of the BC programme.

Box 1: Agencies and partners involved in the delivery of the BC programme

<table>
<thead>
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<th>Main agencies and partners:</th>
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<tr>
<td>Community care settings</td>
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<tr>
<td>Educational settings: primary and secondary schools</td>
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<tr>
<td>Calderdale Metropolitan Borough Council (CMBC) Public Health</td>
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<tr>
<td>Calderdale Clinical Commissioning Group (CCG)</td>
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<td>CMBC Adult Services</td>
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<tr>
<td>CMBC Business Relationship Managers</td>
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<tr>
<td>CMBC Workforce Development</td>
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<tr>
<td>CMBC Early Years Learning &amp; Childcare Service</td>
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<tr>
<td>Kirklees Council, Nutrition &amp; Hydration Older People Working Group</td>
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<td>Rooting &amp; Fruiting (Social Enterprise)</td>
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<tr>
<th>Other organisations and groups that participated in workshops, conferences, training and forums:</th>
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<tbody>
<tr>
<td>Healthy Minds Calderdale</td>
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<tr>
<td>CMBC Better Living team</td>
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<tr>
<td>Calderdale Staying Well team</td>
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<tr>
<td>Community Transport for Calderdale</td>
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Training workshops and network activities were also carried out to promote intergenerational connections and community partnerships. These included the following:

**Therapeutic food, cooking and growing training and workshops**
Care home activity co-ordinators from SFH attended this workshop to gain knowledge and skills to enable them deliver appropriate therapeutic food activity in the care setting. This workshop was run in each of the BC pilot locations. For the workshop organised in Calderdale there were 24 attendees from 11 care settings including SFH.

**Key stakeholder events, conferences and forums**
FFL raised the profile of the importance of community cohesion and support available to achieve intergenerational connections. Some of these events included Public Health regional conferences, Association for Nutrition regional conferences, lectures to nutrition undergraduate & postgraduates at Leeds Beckett University, Early Years Conferences, care home managers’ forums, school conferences, older people’s conferences and local forums and council meetings.

**Care home activity co-ordinators networking ‘brunch’**
This network was held at SFH and sixteen care home activity co-ordinators attended. Ideas were shared among activity coordinators on challenges to activity coordinating and solutions around planning and delivery of therapeutic food, growing and cooking activities. This enabled sharing of best practice and a Facebook platform was formed to share ideas in the future. A signposting resource to therapeutic food and growing activities was also shared. Connections were established among the care home activity co-ordinators who attended and a project to work collaboratively on recipes and reminiscence was developed.
Volunteer Activities

The volunteer activities which took place in SFH as part of the BC programme included a shadowing ‘test-and-learn’ volunteer placement. The shadowing placement was a test to understand how FFL BC could connect high schools with the BC work generally; form closer connections with hard to reach secondary educational settings in Calderdale and elsewhere and to explore how this kind of intergenerational activity could meet curriculum needs around citizenship, health and social care and career progression.

There was also a volunteering activity where four volunteers delivered a bird kebab activity – two from Queen Anne’s high school in Chester and 2 from South Craven in North Yorkshire.

Eleven volunteers from the Soil Association and 14 pupils from two schools (Halifax Academy & Beechill Primary) visited SFH to install a section of a dementia-friendly garden that was designed by the MEA through co-design and consultation with residents, staff and visitors. Along with a horticultural therapist, the team created a ‘sensory kitchen garden’, a space that would be stimulating for therapeutic food activity and reminiscence, and that could be used for intergenerational growing activity.

Care home cooks network

In June 2018, the FFL BC team organised a care home cooks’ network in Halifax, West Yorkshire. The Network was commissioned by Calderdale Clinical Commissioning Group and Public Health and was supported by Calderdale Council’s Adult Services. SFH cooks were part of cooks from 26 other care homes and stakeholders who attended the workshop. In this workshop, care cooks met each other from the local area; listened to speakers relevant to their profession; shared experiences and learning; and identified and discussed challenges and solutions to meeting food, nutrition and hydration guidelines for older people in care settings. Key themes that emerged from discussions in this workshop were budget issues around food in care settings; communication and cooks feeling valued; capacity and working hours; food variety, quality and menu planning; and care home food policy and compliance with food and hydration directives. Participants of the workshop appreciated the opportunity to connect with others in the local area for the first time. Due to high demand for a follow up meeting, FFL found funding through BC to run a second network in February 2019.

Intergenerational links

From March 2016–June 2018, Calderdale Public Health and CCG commissioned FFL to begin connecting schools with care settings. From June 2018, BC supported and continued this work, expanding on the Council and CCG’s original remit and expected outcomes. SFH expressed interest in developing intergenerational connections with schools, local groups and the wider community in the local area from a consultation with BC. Five school connections were facilitated by the BC team over 9 months. The schools are 2 primary schools, 1 secondary school, 1 nursery and 1 academy.

A series of activities were organised between school children and care home residents to foster intergenerational links via food-related activities. These activities included food and growing/outdoor activities that involved building a wildflower bed in SFH; tree planting sessions in the care home’s grounds; implementation of a wildflower, nature-attracting zone; co-designing a dementia-friendly garden; maintenance activities in care home gardens; creation of a wild flower nettle bed to discourage trespassing onto the care home grounds; creation of a sensory kitchen garden, from which herbs and vegetables were used in activities and sometimes by the kitchen; implementation of year-round indoor growing activities and design of growing activities which were included in community activity.

Other intergenerational activities involving school children and residents were bread-making and baking sessions with a local social enterprise. SFH residents also attended a dementia-friendly Memory Café run by year 6 students and Roast Dinner Days at Primary Schools.

FFL helped put in place ways to celebrate benefits of the relationship between SFH and the schools and wider community to sustain the intergenerational connections established. These celebration events were a tea party, for which residents prepared sandwiches and pupils served herbal teas and food, followed by joint activity on tea pot glazing. Pupils also supported the SFH Big Lunch & Jo Cox Great Get Together, bringing the local school and other community members to the care home for a shared celebration of community. Approximately 200 people attended the Big Lunch and Jo Cox Great Get Together. The Big Lunch was also an opportunity to test simple activities to help engage residents and link schools with the care home. In addition, it provided an opportunity to raise funds for the garden. As a consequence of gaps in the local community who attended, that is, ethnically diverse and minority groups (exacerbated by Eid falling), the High School planned to lead on a community links event with SFH.
3.3 Catering quality
The team at SFH achieved Food for Life Served Here (FFLSH) Bronze Award in September 2018. The Food for Life Served Here (FFLSH) award, is an independent award scheme supporting caterers to guarantee that the food on their menus meets certain standards designed to encourage more local, fresh and honest meals. FFL BC worked with SFH to explore the challenges that the care setting was facing in relation to food quality and support them in taking a fresh look at their food. This involved exploring and capturing information about SFH’s existing food offer and developing steps together to enable SFH achieve the Food for Life Served Here Award. At the initial meeting with SFH to explore their journey towards the FFFLSH award, SFH management indicated that they were interested in improving resident dining experience and presentation and timing of food served.

Through the FFLSH Award scheme, SFH made various changes to their food. SFH management controlled purchasing to ensure they got the correct products delivered by working with suppliers to identify products suitable for FFLSH and training the cooks to ensure that only these products were ordered. They ensured that menus were at least 75% freshly prepared and took into account when their menus were planned and checked that meat and meat products on their menu were farm assured.

3.4 Therapeutic food activity
Therapeutic food activity work consisted of indoor and outdoor test-and-learn activities. The indoor test-and-learn activities were focused on simple green care activities with ritual, sensory horticulture and therapeutic food. Residents who took part in this activity were from all three floors in the care home. Sessions were generally an hour long and were supported by 1-2 activity coordinators. Sessions started with some sensory experience e.g. passing round herbs, tasting herbs, trialling some herbal tea and followed by a short activity including mini-herb gardens, sowing seeds, potting on strawberries, decorating planters and making seed pots. This activity lasted for 30-40 minutes and the capacity of residents to engage in this activity varied between weeks.

The outdoor test-and-learn activity sessions were generally 20-45 minutes long and were supported by 1-2 activity coordinators who got residents out in the garden ready for the session. Sessions focused on sowing seeds (broadcasting, dribbling, and drilling), mulching, potting on, deadheading, watering, trimming back, and completing work on the kitchen garden wheelchair access beds. Participation of residents varied; with their general health impacting on their level and frequency of engagement. Visitors had the opportunity to support residents if they were available.

3.5 Resident food experience
SFH wanted a calmer and organised dining experience for residents and a way to promote the quality of food to residents and families. A resident dining training was organised for care staff on how to improve residents’ food experience. However, there were challenges to implement changes to improve the resident dining experience due to food budgets, space and location of the kitchen (these challenges are discussed further in section 8.2).
4. Findings: context of the programme

Context refers to the conditions within which activities linked to the FFLBC programme took place.

4.1 Circumstances of the care home

SFH is well-staffed with four activity coordinators that plan and run activity sessions such as bread-making and reminiscence activities. Despite the availability of this manpower to deliver FFLBC activities in the care home, the presence and attitude of some of the activity coordinators towards the programme were sometimes found to stall the progress in initiating and carrying out the BC activities. There was therefore ambivalence on how the existence of activity coordinator posts contributed to the successful delivery of FFLBC activities.

Firstly, the mere presence of activity coordinators made care staff perceive their role to be tangential to the BC activities and were completely focused on their normative personal care roles.

I think it brings up the whole point of whether having dedicated activity co-ordinators in care homes is a good idea? Or whether all carers should see purposeful activity as part of their role. Is that the way to integrate this? I'm not sure of the answer, but I know activity delivery, separated out of daily care tasks doesn’t necessarily work either. [LPM]

Secondly, there was no clear plan about how activity coordinators should operate.

… they (activity coordinators) are not always told, or it’s not built into their job descriptions that ‘As part of your role, you develop and conduct meaningful activities. You need to test if they work and when they do fulfil their purpose they need to be written down, go in this folder for other carers to use’. This would also be especially useful for frequently staffing changes which occur in care homes.’ Many activity co-ordinators are not directed to plan and prepare ahead of time, for example, a month’s plan of activities, some of which will repeat again next month. You can do this with food activities because, honestly, some older people won’t remember they did it before and for others repeating activities builds their confidence to participate when an activity is familiar. [LPM]

The layout of the building of the care home was seen not to promote some aspects of the programme delivery. In terms of improving residence food experiences, the size of the building was a main issue.

Our main challenges relating to food is communal eating – the size of our building makes this difficult” [FFLSH DCF]

SFH engages in variety of activities for residents but there is no designated space for running activities.

Because they had some more storage room that they turned into additional bedrooms…And they lost space to that process, which has meant they’re not able to really facilitate work in quite the same way, for such a big care home. [MEA]

The indoor space of the care home was not very conducive to readily accommodate the gardening activities.

Because of the indoor space at Summerfield House, it’s not really set up to do gardening-based activities and we struggled with space available and how to engage people with wheelchairs and have enough support… [MEA]
The size of the care home influenced the scope of activities that could be carried out in the care home.

For a large care home, you find there is no designated space available indoors to carry out activities, including food growing, cooking and sharing. Our team and activity co-ordinators are trying to deliver activities in resident dining rooms, whilst respecting their needed to finish eating and vacate the room. This meant carers had to clean up around us. Some carers made quite apparent they saw our being there a personal inconvenience, some complained about it. What they never did in the dining room was see part of their care role to take time to sit with residents and take part in the activities, they'd see it instead as a chance to get on with another functional task. [LPM]

4.2 Policy and practice context of the care home

Some policies and practices in the care home defined the scope and success of delivery of the BC programme. For example, there is no set limit on cost spent on ingredients per resident per day in SFH and the weekly spend on food is £2,300. The freshly food prepared percentage in SFH is 88% and the estimated percentage of plated food wasted, per resident is 19%. Prior to the BC programme, SFH served fresh, original, home cooked traditional food with an emphasis on food first and good nutrition. Breakfast, morning snack, lunch, afternoon tea, dinner, supper is available to residents daily. Meals are served by staff in sittings in the dining room; but residents can choose to eat alone if that is their preference.

Meal quality is ensured, and food is well presented and served by checking the food temperature with a probe as it is sent out to ensure it is at the right temperature. Carers serve the food and regular audits on quality and timing of the service are carried out.

SFH has the following activities taking place to improve their food offer at the care home,

Questionnaires filled out regularly by residents on the choices on the menu. We are trying to improve on the level of involvement with meal times the kitchen staff have. Portion sizes are reviewed regularly with an individual plan for each resident and plate waste is monitored as this would be a signal of declining nutrition for a resident. Not much food is wasted in the kitchen due to the skills of our catering staff and the knowledge that food waste equals wasted money. [FFLSH CF]

There were concerns with some working practices that did not facilitate the implementation of some of the BC activities. As a large care home, SFH has about 130 care home staff with varying shift patterns and relatively high staff turn-over. This made the engagement of staff in activities such as staff training difficult to carry out.

I definitely think it makes a difference to some of the issues we’ve got at Summerfield. We looked at staff training, didn’t we, but it’s really hard to develop staff training when you’ve got rotating and night rota staff, people that are on ad hoc (shift patterns). [MEA]

As a working culture in SFH, there was more priority on personal care rather than food.

People’s personal care is a priority, people’s obviously dignity matters to staff, things like you’ll see carers have taken time to co-ordinate a ladies’ shoes, cardigan and jewellery, but whether that lady has something meaningful to fill her time with, or how beneficial it might be to that person’s physical and mental health to have spent some time outdoors today, doesn’t seem to factor with many carers, from my observations. [LPM]

Yeah, I think just before we arrived, they turned an office space into another bedroom. [MEA]

SFH has a protected mealtime policy where during mealtimes, there is no interference with residents’ meals. This created an opportunity to improve residents’ dining experience as part of the programme.
What I’d say they do well around the food experience in terms of dining is they have protected meal-times, mainly because of the size of the home. You’ve got three dining-rooms catering to over 35 people, and for that reason it’s protected, if families were to be arriving for visits, health professionals for their reasons, you’d not have the dignified dining experience they do. [LPM]

However, this mealtime policy did not encourage staff to meaningfully interact with residents during mealtimes.

…but crucially I think it doesn’t allow for staff to sit with people to talk to them while they eat, or when you see them assisting with eating, they often stand at the side. You can imagine, this standing at the side of you when they’re assisting with eating. Staff sit down as well, but it’s not encouraged for staff to sit and talk, just to talk, chat, while people are eating – there’s a culture they’re to be up, doing jobs – so although you’ve got a quiet and dignified experience in some respects, the resident dining experience at Summerfield could be so much better. [LPM]

Moreover, there is not enough space to invite guests to eat with residents.

[There’s] not enough space to do this on a regular basis but if we have requests for a relative or friend to eat with a resident then we do accommodate that. [FFLSH DCF]

Residents in SFH are presented with choice menus and provided with ample time to eat despite the large size of the care home. Staff also try to accommodate residents’ preference of meals where possible.

What they do do well at Summerfield is the day before food is served, they will go and give choices. Not for breakfast – breakfast is always cereal, toast and a selection of, like an English breakfast, a selection of two meat and some eggs or whatever they want to have, so that’s breakfast. But for lunch and for dinner, they’re offered a choice of what they’d like between two to three options, which isn’t always practice in a lot of care homes. [LPM]

4.3 Role of food in the care home prior to the FFLBC programme

The pre-existing approach to food in the care home before the implementation of the BC programme had a bearing on the uptake and delivery of the programme. SFH was noted to have a strong ethos around good food and food-related activities, creating a conducive ambiance to deliver the programme.

… the ethos in the home is still a very ‘yes’ attitude, … which is a big plus for working there, because we’ve never not had the ‘yes’ attitude, really, from the management, whereas in other places it’s taken quite a long time to build that attitude….Yeah, it’s a lovely environment to work in... [MEA]

The cooks in particular were key drivers to improve residents’ food experience. They had a positive food ethos and relevant past catering experiences that facilitated the uptake and delivery of the BC programme activities around catering quality.

I do wonder if it wasn’t those particular two cooks whether that would have been. It was very much based on their old-school approach. I see in other care homes the cooks can be quite influential in terms of what’s put out, and if you have a cook who’s really not as committed…there’s a lot more processed food, the easy option. [LPM]

The care home had already developed interest in gardening activities and had developed some initiatives and gardening-related activities prior to signing up for the BC programme. However, the gardening and growing activities needed significant uplift. On the other hand, food-related activities were limited to a weekly baking activity and party events prior to the BC programme.
5. Findings: programme perceived mechanisms

We refer to programme mechanisms as the key social and psychological factors that influence the decisions and actions of stakeholders to engage or disengage in the programme, leading to any programme-related impacts on the stakeholders.

5.1 Staff confidence

Staff confidence around food developed through workshops of the FFLBC activities and this was a key element that promoted engagement and better delivery of the BC activities.

…and also it goes all back to (MEA) work on confidence building through activity. I think we must say as well at this point there’s been some amazing practice from [the activity coordinator], who is always organised, has engaged with us entirely, and she’s benefited and grown in her food activity and now does a lot more of it. Her confidence levels increased, she came on therapeutic food activity training, she took away all the resources, she uses them… [LPM]

5.2 Staff perceived role and value of the programme

It was noted that most of the care staff at SFH did not perceive their role to include engagement in BC activities and fully dedicated their time to only their normative resident personal care such as assisting residents with washing, dressing and feeding.

Yeah. I think, staff-wise as well, it comes back to the fact that whenever there’s an activity, because the home has activity co-ordinators, the carers see that as a chance to run away… Also, you have a staff attitude towards a very much task-based culture – get it done, get them in, get them fed, then get them out [LPM]

5.3 Resident capacity to engage in the programme

Resident ability and level of engagement in the BC programme were contingent on their physical and mental capacity: their individual personalities and ‘in-the-moment’ mood.

Kate likes baking and when the children come in. She used to be a nursery nurse. After she was struck with stroke, she did not engage in activities anymore. Health is a big determinant of residents’ engagement in the BC activities. She is wheel-chair bound. Has mild cognitive impairment following the stroke. [CA1]
Capacity had immense impact on the ability of residents to engage in activities. [AC4]
James is gradually losing mental capacity. He is old, and his physical capacity is deteriorating. He has been involved when the children come around. He is normally quite happy in his room with his newspaper and watching his sports. [DMCH]
Joyce have been withdrawing recently in the activities; becoming a bit insecure, a bit muddled because of her health but she still enjoys going to the garden with her best friend. [AC3]

In terms of resident personality, some residents would (or not) engage in the activities depending on their personal preference for activities of such nature. Engagement in the BC activities were just not compatible with personal traits of some of the residents.

Rihanna is usually enthusiastic in activities and she likes the social interactions. She likes the baking and likes to go to the garden. She enjoys drama therapy. She likes the music sessions and the chair Zumba. She enjoys her life the best she can. She is in her 90s. She has got a very positive attitude. Apart from the social benefits that resident derives from activities, she is usually physically active despite her mobility issues. [AC2]
Paul says he enjoys doing things. He enjoys the social aspects of things. He is usually the only man amongst the ladies. He like interacting and it is sometimes that comes out naturally from him. [AC2]
Jonathan does not necessarily get involved in the activities. He is more of a solitary man. He only sits and observes. He has dementia. He likes only being in smaller groups. By choice, he does not want to get actively involved in activities. Noise is overwhelming for me. He watches what goes on. [CA2]
For one resident, her preference for the activities overrode limitations of her physical and mental capacity to engage in activities.

Christine is on residential floor, struggles with the eye sight, hearing but has a go at everything that is on offer. Her memory is not fantastic. She always contributes - comes out with songs and poems. She has lot of little Yorkshire sayings. She likes joining in activities. She was fairly quiet when she first come to the care home. [AC2]

Residents’ mood varied daily and the ability of residents to take part in the BC activities depended on their ‘in-the-moment’ mood on the day of the activity.

Beatrice can be quite difficult to get her involved in activities and it depends on her mood on the day. She has got dementia and does not tend to go out much. [DMCH]

5.4 Inclusivity of residents in activities
SFH residents’ involvement in the BC activities depended on the extent to which activity coordinators included them in the activities.

... but it’s very exclusive of certain groups. They ask everybody, ‘Do you want to join an activity?’ but what you seem to see is the activity co-ordinators ask the same people they know they’ll be able to manage. I don’t think that’s done on purpose, but again it’s cultural. [LPM]

6. Findings: perceived outcomes linked to the programme
6.1 Residents
Proxy information about the benefits derived by residents in SFH were provided for 30 different residents by 4 activity coordinators, 2 care staff and the deputy manager of the care home.

Residents whom proxy information was provided for were conveniently selected by interviewees. There was representation of residents from all three floors and with variations in capacity and capabilities to take part in the BC activities. Duration of stay of the selected residents ranged from 6 months to 7 years. The length of time activity coordinators and care staff had known these residents was a minimum of 5 months to a maximum of 6 years. These data were corroborated with information from the other interviews with the LPM and MEA.

Table 2 Impact of BC activities on aspects of residents’ health and wellbeing

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<tr>
<th>Domains of impact</th>
<th>Levels of impact (n= 30)</th>
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<tr>
<td></td>
<td>Negative n (%)</td>
</tr>
<tr>
<td>Social</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Mood</td>
<td>2 (7)</td>
</tr>
<tr>
<td>Wellbeing</td>
<td>2 (7)</td>
</tr>
<tr>
<td>Nutrition and diet’</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Enjoyment of food</td>
<td>0 (0)</td>
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* One response was a ‘Don’t know’
Social

Majority of the sampled residents (77%, n= 23) were perceived by interviewees to have derived positive or very positive social advantages from the BC activities. For instance, the BC activities helped residents to socialise more with other residents in the care home. Residents who normally would stay in their rooms came out from their rooms more and interacted with other residents.

Suzy is a quiet person and only came out of the room during meal times. Persistent encouragement got her out of her room eventually and engaged in the activities. The activities enable residents to get to know each other. It was a good turn around for the resident - it was about giving her time and gradually drawing her into it” [AC2]

“Benedicta likes walking around. She has a friend who she normally associates with and now that we have the garden, both go to the garden. With the garden, it has also provided an opportunity for her to socialise more with other residents and this generates communication as well. [AC4]

The social interaction between residents was boosted by the intergenerational visits of the schools.

Daniel engages with children and those who come along as well. Normally he sits with a couple of friends and does not associate much with people. [DMCH]

Seeing that happen (intergenerational activities), that kind of bonds them a lot more than I think I’ve seen in other projects before, yeah. [MEA]

The gardening and growing activities created the opportunity for residents to go outdoor more and it exposed them more to nature.

I think an impact then was there was more opportunity to go outdoors and a reason for going outdoors a reason for going outside and interact with nature because as the garden developed, and the co-design aspect meant residents feeling part of that. [LPM]

As a result of the BC activities, stronger interactions were established between carers and residents and even enabled the carers to get to know residents better.

This activity also increased social interaction between resident and carer and made carer to know more about resident. [ACA]

The school visits to the care home encouraged shared experiences between residents and the children which led to the development of social bonds between some residents and the children.

And you get things like we had a young girl meet Agnes, a white British older lady and she told us she’d never spoken to an old white person before except for teachers, who she didn’t think of as particularly old but fairly old, they’re in their forties I suppose and fifties. She hadn’t spoken to an older white person and they sat chatting, we were doing a food activity, they really wanted to touch each other’s hair because Agnes had silver soft white long hair and Suwita (pupil) wanted to feel, she said, oh your hair’s so strong, they started having these conversations. They decided to plant chilli plants together and Agnes said she’d never had a curry and the Suwita started speaking about curry and cooking curry with her mum, so they had this whole conversation about, well we’ll grow the chilli plant and then we’ll design our own thing and we’ll make a curry and we’ll show the rest of the class how to make the curry and then we can have it together… [LPM]

For almost a quarter of the residents (23%, n= 7), interviewees felt there was no change to their social interaction because of the BC activities. This may be due to the varying capacity and capability of residents to engage in some of the activities.

David’s mental capacity has deteriorated. He has dementia. He is usually disorientated. Very amenable but will not come to the dining for meals. [DMCH]

Yeah and we definitely had in those indoor sessions a mix of all three levels and with having to kind of try to think about how people can help one another and often just getting used to like people having to wait and encouraging them to talk to one another or helping each other which was really hard wasn’t it at times. [MEA]
Communication was also a barrier for one resident that prevented her from taking part in activities and benefitting socially from them.

Communication barrier (she is Asian) prevents Aishwarya from being actively engaged in activities but she watches as activities are going on. [DMCH]

**Mood**

Interviewees linked the positive or very positive mood of more than half of the selected residents (63%, n= 19) to the BC activities. Such mood-related benefits for residents were heightened spirits, happiness and less anxiety.

- Vivian enjoys the sessions in the moment even though she does not remember them after some time. [AC2]
- When Dora is told what is going on although she does not take part, it still enlightens her mood... The energy generated by these activities still have a positive impact on the mood of some of the residents although the resident does not actively engage in the activities. [DMCH]
- George’s mood has increased a lot when the BC activities started. He used to be getting quite frustrated prior to the BC activities. [CA2]

**Wellbeing**

The results from the proxy information about resident’s wellbeing showed that 80% (n= 24) of the residents had improved wellbeing because of the BC activities. It was noted that the BC activities provided an opportunity for meaningful and purposeful activities and raised residents’ self-esteem.

- Prosper is on the dementia floor and as soon as he is in the garden he is a different person (positive). [SC]
- Activities give Veronica a sense of purpose. [CA2]
- Dorcas engages in conversations. Stress and anxiety taken away when children come in. Children coming around brings out her true self. [DMCH]
- Activity makes Emma more physically and mentally active. [AC1]
- Fantastic – holistic approach to health and wellbeing. [CL]
- Being able to get out in the garden gives residents a sense of responsibility and ownership. [CL]

**Diet and Nutrition**

BC activities were found to improve the diet and nutrition of half (n= 15) of the residents selected.

- When resident is down for activities it is easier for him to go into the dining room to eat. [AC1]
- Marc is eating better as a result being involved in activities such as baking. [CA2]

However, the responses for almost another half of the residents (n=14) showed that their diet and nutrition were not affected by the BC programme. One of the reasons behind this neutral effect of the BC activities on diet was because residents generally had a good diet irrespective of the BC programme.

- Residents eats very well generally… Resident nutrition is generally OK. [AC1]

**Enjoyment of food**

Interviewees indicated that the BC programme had increased the enjoyment of meals for two-thirds of residents selected.

- Also seeing the impact that it had with conversations with residents about how much they enjoyed the food …[LPM]
6.2 Staff
There were positive impacts of the BC activities on staff wellbeing. Staff who engaged in the BC activities felt supported, valued and experienced a boost in their morale around food in the care home.

I think, coming back to staff morale, them being supported around the food and growing activity has definitely boosted morale for the activity co-ordinators. They feel more valued; they feel more supported. The cooks, through the Served Here and the food quality work and also the intergenerational work they’ve been able to get involved in and the community events work like The Big Lunch, the cooks have told me, ‘It’s really lifted our spirits. We feel more valued. We feel inspired when those things go on to, ‘What can we do today and how can we support it?’ If the children come, they’ll make a fruit bowl. The morale from feeling supported around the food and growing work and, ‘Can we go and pick some of the herbs? What are you doing next in the garden?’ and interest there. There are some real positives around the food work there. [LPM]

The BC activities also enhanced communication between staff and residents.

… From the work you (MEA) did over summer, we got a lot of feedback from carers saying that the regeneration of the garden had given them a really interesting space for carers now to take people out to look at and talking points, and also a lot more families were using the garden and green space. [LPM]
… staff able to get residents out in the garden doing things. [SC]
… staff realising that care home is someone’s home. Transition from care home to a home. Staff getting to know residents better…[CL]

Engagement of SFH cooks in the care home cooks network had enabled them to establish networks with other cooks in Calderdale and gained knowledge on good food practices for the care home.

We went to the FFL cooks network. We got to hear interesting speakers and talk to and learn from other care home cooks. [FFLSH DCF]

SFH cook’s involvement in wider food-related activities such as intergenerational exchange and volunteering days increased their motivation, confidence and morale around food.

Neighbourhood ‘get togethers’ & volunteering days are something different for the kitchen staff, FFL involvement keeps you motivated and staff morale up – this work creates a buzz in the kitchen. [FFLSH DCF]

6.3 Residents’ relatives
It was reported that some relatives expressed satisfaction of the care of their relatives in the care home as a result of the BC activities taking place in the care home.

We’ve had a positive response when we have a celebration of the ‘Served Here’ award from some residents families coming to celebrate the food quality and we have verbal feedback that they’re really pleased to see Food for Life have engaged with that award and that they, you know, it gives them peace of mind that their family member is being well fed and hydrated and looked after around food. So, we’ve had that verbal feedback, you know, that comes from sitting in the visitor’s room: ‘Who are you?’, ‘We’re Food for Life, we did this, this…’ ‘Oh, you’re the one’s doing this’ and so on. [LPM]

6.4 Schools
Through the intergenerational visits of schools to the care home, school children were observed to show acts of empathy towards residents in the home.

Seeing the knock-on effect on young people’s attitudes to residents and the care home in general. Students had changed their own attitudes by getting to know the home and residents and this had been passed back to the general school community and had stopped the negative behaviour by young people walking past the property. [GGNC]
Also for older people sometimes who kind of, in some ways regress a little bit, in terms of they don’t want to share or I’m not having so and so sitting next to me, I’m not sharing that, you know it built empathy
and respect between each other doing an activity together but also built when you saw the children and older people together the impact of empathy and respect there, you could sense it. [LPM]

... and like seeing things in Summerfield like older people dropping walking sticks and when children first came in they wouldn’t think to pick it up and now it’s like oh she’s dropped her walking stick she needs that. Those are massive impacts for children and their way of thinking about old people and their way of behaving towards others and their patients...Yeah, and there was a lot of students shouting out, wasn’t there, as they walked past, and that had reduced down... and that was in two months, wasn’t it, at the start of the project, so it very quickly showed how much that... this project’s been presented back to the school. [MEA]

... and then going back to school and talking to the other students about, ‘You shouldn’t be doing this. These are our friends. These are our neighbours. You’ve got to respect them. [LPM]

The BC intergenerational activities fostered team-building among pupils who engaged in these activities.

... and then seeing them work as a team around that, which was lifting tyres and sacks of soil up a steep banking. [LPM]

School children were also seen to develop new experiences as a result of their visits and interaction with residents in the care home.

Knowledge exchange – children learning about what older people use to when they were younger and older people get to know how childhood is experienced in the current generation [SC]

Getting to meet older people and gain knowledge and experience from older people [SCAD]

There was a little, tiny scratch on a young girl, but seeing the children who had never walked up a banking and had to learn how to walk up a banking, never pushed a wheelbarrow, never touched soil, never touched a worm, seeing those things happen [LPM]

There was transformational culture around food in the schools that engaged in the BC activities and schools developed links with the wider community as a result of the FFLBC programme

Another knock-on effect which I haven’t spoken to you about is that a teacher contacted me about their morning food service, and they wanted to buy in organic fruit and vegetables for students and link with food, care community provision in Calderdale, and that’s come out of this project... So that’s another one in terms of adding value to the work they do at the school, recognising that Better Care has provided that level of therapeutic food that would be then beneficial back in the school. [MEA]

The schools really value the children having an opportunity to go outside and grow and use food that they’ve grown in activities. It also links to the high school. [LPM]

Friendships were also formed between school children and residents through engagement in intergenerational activities.

.. and also for me the impact of kindness and friendships that have been built through the activities from the children coming in...One major impact for me like on a personal level is the young British Asians interacting with older white British people and that getting them understanding each other and actually seeing they’re not that different and we’ve got commonalities and we do things different and explaining that to each other, to me that’s been a really important and really essential thing. [LPM]

6.5 Care home

The cooks in SFH testified that the food practices in the care home had improved as a result of achieving the Food for Life Served Here (FFLSH) Award. They had realised an improvement in the quality of food prepared, savings on cost of food and reduction of plate waste.

We looked at our food practices including food and plate waste. FFL support in this area & on portion sizes means we have cut down on food waste and in (turn) saved money. [FFLSH DCF]

We hadn’t realised our eggs weren’t free range, there was a little more cost involved in changing to free range, but so much you wouldn’t do it for the hen’s sake! And we’d saved money elsewhere. [FFLSH DCF]
7. Discussion

7.1 Summary of main findings
The purpose of this evaluation was to understand how a co-design test-and-learn whole setting approach to food could impact on the health and wellbeing of residents and their relatives, volunteers and staff in a large care setting. The findings of this evaluation will hopefully support programme implementers and commissioners planning the refinement or scaling out of the programme in care settings.

Over an eighteen-month period, the Food for Life Better Care team collaborated with staff and residents at SFH to focus on food and food-related activities as a social experience and a bridge to the surrounding community. FFL BC sought a comprehensive approach, in that the programme was informed by a whole settings approach to consider 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.

There were several benefits of the programme to residents, staff, residents’ relatives, schools and the care home itself. Thus, our analysis showed that residents derived social, affective, nutritional and general wellbeing benefits from the programme. Staff who engaged in the programme were noted to feel valued, supported and developed a higher sense of morale in the care home. Communication between staff and residents were observed to have improved during the implementation of the programme. There were testimonies from staff about residents’ relatives’ satisfaction of care due to residents’ exposure and engagement in the BC activities. The FFLBC activities had a positive impact on school pupils who visited SFH to undertake intergenerational growing, gardening and other food-related activities with residents. There were observed and reported increase in empathy for older people; counter-stereotypical behaviour towards older people; and development of friendships with residents through the intergenerational work. The quality of food was noted to improve during implementation of the BC programme in SFH and management had realised savings on food cost and reduction of plate waste.

These observed outcomes related to the programme were derived within particular contexts of the programme delivery. SFH was found to be a care home that was well-staffed with activity coordinators and care workers to match its large size. However, the activity coordinator role was sometimes perceived to prevent care workers from engaging in the programme. The presence of the activity coordinators made care staff perceive their engagement in the BC activities as peripheral to their ‘care’ responsibilities.

SFH is a care home with a positive ethos towards food, demonstrated through a flexible budget on food and food-related activities and a team of enthusiastic cooks. However, it was sometimes felt that more priority was given to personal care rather than food.

Key to the context of delivery of the programme was the partnerships that the programme established with organisations and agencies such as the CMBC, schools and local community
enterprises. Such partnerships facilitated intergenerational activities between SFH and its wider local community.

Linked to the context within which the BC programme was delivered are the mechanisms or processes that facilitated the decisions of key stakeholders in engaging in the BC programme. The main mechanisms depicted from the evaluation were staff confidence, resident capacity, personality and mood on the day. Staff were more likely to engage in the BC programme if they had the confidence around food and delivery of the activities related to the programme. Residents’ engagement in the programme mostly depended on their physical and mental capacity to take part in the programme. Some of the BC activities did not fit with the personality profile of some of the residents; and these residents avoided taking part in the programme activities. Where residents’ capacity and personality were not hindrances towards their participation, their in-the-moment feeling still determined whether they were likely or not to take part in activities.

7.2 Challenges associated with implementation of the programme
Key constraints around implementation of the programme were around resources, organisational characteristics and individual and cultural challenges. Limited monetary budgets placed constraints on programme activities. There was also limited time to cover all the domains of the whole setting framework. As such, areas around staff capacity development could not be fully addressed, especially in the context of the prevailing staff working culture. The shift rotation patterns of care staff made it challenging for them to take part in some of the training and other programme activities. This meant that care staff did not have the opportunity to acquire the knowledge and develop the skills needed to implement the programme activities. The built environment of the care home limited the way some of the programme activities could be carried out; such as the indoor gardening activities and improving residents’ dining experiences through the ways residents’ meals were served and presented.

Care staff and residents’ relatives were not willing to engage in the programme activities despite the flexible delivery of the programme. SFH staff culture and attitude towards food made it challenging to fully engage them in the BC activities. For most care staff and some activity coordinators, buy-in to the programme was low. It was felt that care staff did not perceive their involvement in the programme as part of their routine duties in the care home. Some activity coordinators did not also place high value on the programme and were therefore recalcitrant in engaging and promoting the programme. Multiple efforts from the programme and care home management to involve residents’ relatives in the programme were to no avail.

7.3 Limitations of the evaluation
There are some limitations to this evaluation. The research did not record the longer-term consequences of the FFLBC work at SFH but, rather, focused on the short-term processes of implementation and the immediate impacts. We attempted capturing the impact of the WSA approach on residents that are most engaged in the FFLBC activities. However, we did not adopt a structured approach to gathering the perspectives of residents directly. Our request to obtain proxy information for all residents in the care home could not be granted by the care home management. Nevertheless, the use of the in-depth interviews and a proxy tool for gathering staff perspectives helped us record staff perceptions about a purposively selected
number of residents at the care home towards the end of the programme. 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.

7.4 Implications for practice and policy
Social and therapeutic 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.

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.

8. 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 work at SFH is a showcase of implementing a whole settings approach to food in the context of a large care home setting where staff buy-in is essential to overall programme delivery. Our evaluation findings suggest that residents social, affective and nutritional well-being are likely to improve through the FFL BC whole settings approach to food when the following contextual environment is provided:

- Care home leadership and management include clear plans and roles on food-related activities in the tasks and workload of care staff
- There is available space and the built environment of the care home can accommodate programme activities
- Care setting has adequate budget available for procuring programme resources
- Staff turnover is low, and staff shift patterns enable care staff to be available to take part in programme activities
- There is a strong food ethos in the care home that prioritises food-related activities

The WSA to food has beneficial impacts on residents, relatives, staff and the wider local community and is likely to be transferable to other care settings. The FLL BC WSA to food embodied ambitious aspirations to improve the place of food and food related activities for older
people in care settings. This is 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 timely.

9. References

Main sources


PG Professional and the English Community Care Association (2006) Care Homes: through the eyes of the consumer. London, English Community Care Association


**Additional sources**


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 XXXXX Better Care Food for Life 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>Negative impact</th>
<th>No change</th>
<th>Positive impact</th>
<th>Very positive impact</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socialising with other people</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood</td>
<td></td>
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<tr>
<td>Mental wellbeing</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Diet and nutrition</td>
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<tr>
<td>Enjoyment of meals &amp; eating</td>
<td></td>
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</tbody>
</table>

Appendix 3. Logic Model Care Homes

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Example Activities and Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>BIG Lottery Funding</td>
<td>Care Settings: Staff participate in making changes to improve food culture.</td>
<td>Increase in number of settings working towards and achieving the FFL Award and better quality food provision (2b)</td>
</tr>
<tr>
<td>Multisite/CCG/Public Health</td>
<td>Participation from CCGLs, Age UK, health and social care leaders, and wider stakeholders in making strategic changes to improve food culture.</td>
<td>Increased capacity and capability of care setting staff through knowledge, skills and confidence (Ann 4, 5 and 46)</td>
</tr>
<tr>
<td>Care Homes</td>
<td>Participation from older people, friends and family in development of activities in care settings.</td>
<td>Care settings take a whole setting approach to food e.g. whole setting food policy, introducing therapeutic foods, increasing meal times. (Ann 3b and 4c)</td>
</tr>
<tr>
<td>Ethnographic</td>
<td>Participation from health and social care teams and wider related workforce in supporting changes to improve food culture.</td>
<td>Greater awareness amongst care workers of risk factors that may lead to malnutrition in older people and improved monitoring of malnutrition.</td>
</tr>
<tr>
<td>Research findings</td>
<td>Community dining opportunities and improved food environment in settings.</td>
<td>Improved indicators of wellbeing and nutrition for residents of care settings (2a) e.g. through strength, ability to stand from chair unassisted.</td>
</tr>
<tr>
<td>FFL staff expertise</td>
<td>Support for schools and care settings to work together on intergenerational linking projects.</td>
<td>Increased confidence in schools and care settings in working together (Ann 4)</td>
</tr>
<tr>
<td>Expert partner organisations</td>
<td>Care Settings: Staff participate in making changes to improve food culture.</td>
<td>Increase in the number of settings working towards and achieving the FFL Award and better quality food provision (2b)</td>
</tr>
<tr>
<td>FFL central support</td>
<td>Participation from CCGLs, Age UK, health and social care leaders, and wider stakeholders in making strategic changes to improve food culture.</td>
<td>Increased capacity and capability of care setting staff through knowledge, skills and confidence (Ann 4, 5 and 46)</td>
</tr>
<tr>
<td>FFL award scheme</td>
<td>Participation from older people, friends and family in development of activities in care settings.</td>
<td>Care settings take a whole setting approach to food e.g. whole setting food policy, introducing therapeutic foods, increasing meal times. (Ann 3b and 4c)</td>
</tr>
<tr>
<td>Strong existing networks</td>
<td>Participation from health and social care teams and wider related workforce in supporting changes to improve food culture.</td>
<td>Greater awareness amongst care workers of risk factors that may lead to malnutrition in older people and improved monitoring of malnutrition.</td>
</tr>
<tr>
<td></td>
<td>Community dining opportunities and improved food environment in settings.</td>
<td>Improved indicators of wellbeing and nutrition for residents of care settings (2a) e.g. through strength, ability to stand from chair unassisted.</td>
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<tr>
<td></td>
<td>Support for schools and care settings to work together on intergenerational linking projects.</td>
<td>Increased confidence in schools and care settings in working together (Ann 4)</td>
</tr>
</tbody>
</table>

32