



Comparison of activity provision and the arts for older people

Sylvie Silver 2015

“Every day you may make progress. Every step maybe fruitful. Yet there will stretch out before you an ever-lengthening, ever-ascending, ever-improving path. You know you will never get to the end of the journey. But this, so far from discouraging, only adds to the joy and glory of the climb.”

Winston Churchill : Painting as a Pastime (1950)



Gary Glazner Creative Poet: New York

Photo courtesy of Michael Hagedorn

Acknowledgements

I have been truly humbled by the generosity of spirit, openness and kindness shown to me by everyone I met on my travels. At the close of my report I have listed all the venues I visited in the hope that it will be seen as a tribute to every single person I spoke to during my multitude of visits. I do however need to single out a few individuals as, without their input, I would not have gained the vast wealth of knowledge that I have brought back to inform our work here.

In the USA Shelley Evans became my guide and mentor helping me to navigate the intricacies of the care system. Her contacts list allowed me to set up many of my visits. Deb Kearney shared her knowledge with a passion that will stay with me. Lynne Hambleton has become a friend for life whilst sharing her thoughts on the cultural base that informs older peoples care across the States.

Renee Smith welcomed me to Sydney, Australia and showered me with support, contacts and car rides without which I would not have had gained such a great insight into the way things work there. I am grateful to Karen Martin for introducing me to Renee and her network of colleagues. In Adelaide I was royally hosted by a past Churchill Fellow and old UK ally- Andrew Larpent. His entire team at Southern Cross Care took me under their wing and treated me as one of their own. The cup of human kindness also sits with Kay Price who not only shared her views but opened the doors of her home to me too.

My heartfelt thanks go to the team that look after the Winston Churchill Travelling Fellowships. From my first contact they have been supportive, informative, caring and incredibly generous. It was beyond my dreams to be able to travel and learn about our niche, but ever so important, subject. I hope to fulfil my share of the bargain by inspiring others in the UK to share my learnings and improve the quality of life through meaningful engagement for older people in the future.

The NAPA Board of Trustees were more than enthusiastic in their support of my application. Our staff team of just 5 amazing people are often credited with helping NAPA to 'punch above its weight' but they excelled themselves by covering my time away without hesitation.

Lastly, my long suffering family deserve a mention for, without their selfless backing, NAPA would not hold the treasured place it does as the champion of activity provision.

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Glossary

Activity Provision An umbrella term for meaningful purposeful engagement that encompasses all descriptions such as Therapeutic Recreation, Diversional Therapy, Lifestyle, Leisure and Well Being.

Activity Specialist An individual employed specifically to address the quality of life of people living in care settings including the need for mental well –being, social engagement and physical activity along with cultural and intellectual stimulation and meeting spiritual needs.

BMA British Medical Association

CPD Continuing Professional Development

Cert 4 Leisure and Health A nationally recognised qualification in Australia equivalent to A level standard in the UK. Offered by TAFE: Western Sydney Institute as a taught course over 18 weeks

CRTS Certificate in Recreational Therapeutic Services a common qualification in the USA

DTA Diversional Therapists Association: Australia

IL&M Institute of Leadership and Management

NAAP National Association of Activity Professionals: USA

NAPA National Activity Providers Association

QCF Quality Curriculum Framework for all accredited qualifications in the UK

WCMT Winston Churchill Memorial Trust



Shelley Evans, Director of Activities, Music Therapist, Board Member for NAAP, De May Living Centre, Finger Lakes, USA

Deb Gibson, Activities Director, Brooke Foundation, Olney, Maryland, USA at work in the Activity Team Office.



Travel to learn...

Return to inspire is the motto of the

Winston Churchill Memorial Trust

Where did I go?

The USA and Australia

What did I learn?

I reinforced my belief that every older person wants, and deserves, a sudden death. By this I mean that everyone should have a meaningful and fulfilled life, regardless of disability or frailty, until the very moment they pass away. My travels gave me the insight and thinking time to realise how this can be achieved by training and developing activity providers and ensuring that they are well supported by the specialist skills of health care and arts professionals.

How will I inspire others?

- By writing this report in a way that busy people in the care sector will read it
- By sharing my learning through public speaking engagements based on this report
- By using the NAPA network to share this report and what I have learnt

My aim

In brief, was to compare what two other nations are doing to provide training and support for activity providers and creative artists with what happens in the UK.

My major findings

- Training and formal qualifications do make a difference
- Lifestyle and health are inseparable
- All care professionals identified a lack of training around leadership in the care sector
- Creative arts professionals can support quality activity provision if enabled to do so
- Sharing international knowledge benefits everyone

My recommendations

- Every activity specialist should hold a formal qualification relevant to their work
- Qualifications up to degree level for activity leaders should be available
- Greater attention must be paid when Care Planning to link health, well-being, lifestyle and leisure.
- Care settings should consistently seek the support of health care professionals and creative arts professionals
- Training and development in leadership skills must be formalised and made available to all
- We should all aspire to a 'Sudden Death' for every older person

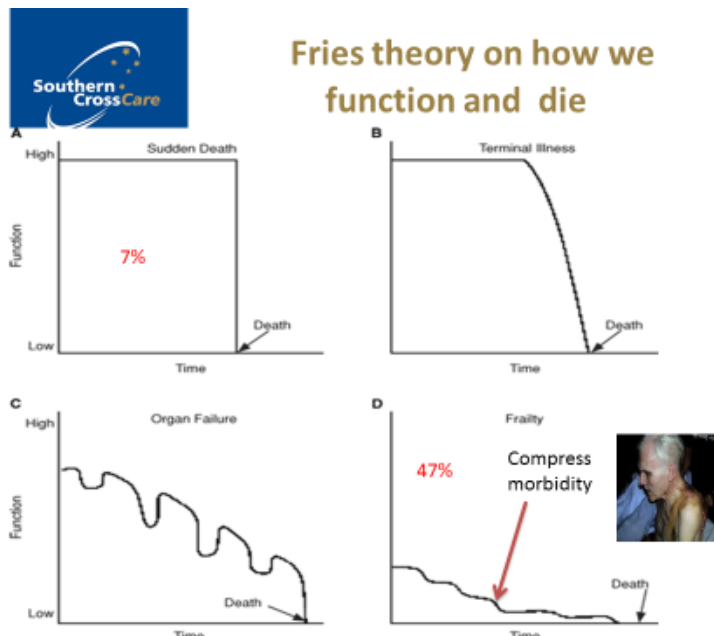
Summary of comparisons of my observations between Australia, the UK and the USA

	Australia	UK	USA
Training and Qualifications	Many employers expect Activity Leaders to hold a recognised qualification	No expectation of holding a qualification	Many States require CRTS or similar qualification
University Degree Level courses	Degrees in Diversional Therapy and in Recreational Therapy	None available	Degree in Recreational Therapy
Career Pathway	Activity Assistants – few qualifications Activity Leaders with qualifications	Activity Assistants - no qualifications Activity Leaders – a small number have qualifications	Activity Assistants - no activity specific qualifications but many had a College degree in a related subject Activity Leaders and Directors of Activities - range of qualifications available
Relevant Leadership Training	Not standard	Not standard	Not standard
National representative organisation	Diversional Therapy Australia DTA	National Activity Providers Association- NAPA	National Association of Activity Professionals - NAAP
Use of creative artists	Many settings routinely use on a sessional basis	Few settings use and tends to be ad hoc not regular	Many settings routinely use and some are permanent employees
National Creative Arts Organisation	Australian Creative Arts Therapies Association	None	National Centre for Creative Ageing
Funding	Each State funds health care, the Federal (central) Government is responsible for social care – Assessment based	Central government funds free health care Local government responsible for social care – means tested and rationed	Insurance based or privately funded
Keen to form international network	Yes	Yes	Yes

Sudden Death and Activity Provision – What's the link?

If I ask my family and friends how they would like to die they will say things like in my sleep or a massive heart attack. In other words they want a Sudden Death. They will want to be doing things that make them smile and things that have meaning and purpose to them right up until the point of death. People who live in care settings are no different. Commonly they will be coping with disability or frailty as a consequence of ageing and their quality of life may vary.

But, in my experience, they have the same desire for a Sudden Death as everyone else. Nobody has ever told me that they want a long slow decline. Care providers are responsible for ensuring the good general health of people. They are responsible for activity provision too although it rarely gets the same attention. If we are to achieve the death that most people seem to want then we need skilled activity specialists to work alongside clinicians to support the care team in order to achieve this.



A presentation that I attended in Australia crystallised my thinking around maintaining and regaining skills for those who are frail and living in care. Our aim should be to promote healthy active ageing. Providing physical activity and exercise along with meaningful and purposeful engagement is vital. We must also value social connections and the relationships that motivate people to engage more if we are to aspire to a Sudden Death for all. This is known as Compressed Morbidity.

The idea behind compression of morbidity is to squeeze or compress the time horizon between the onset of chronic illness or disability and the time in which a person dies.

(Illustration courtesy of Jo Boylan, Southern Cross Care, South Australia)

I have in the past raised a few eyebrows when stating that I was delighted that my Mum had a Sudden Death. I don't mean that I wished her life away but that she did not experience a long slow 'lingering' unhappy journey to meet the maker that she believed in. I don't believe this was luck but thanks to the lifestyle that we created together. Mum was 89 years old, living with vascular dementia with very poor short term memory. We had to keep an eye on her health as she was prone to anaemia and urinary tract infections. She lived close to the family in sheltered housing but shunned all the group activities on offer in the scheme. As her main carer I ensured that she had access to all the activity that she enjoyed: the easy crossword in the daily paper, watching the squirrels on the bird feeder by her window, listening to her favourite CD's. She enjoyed TV in the evenings and chats with visitors as long as they didn't stay too long as it tired her out! We maintained her physical health by expecting her to make the cups of tea, to strip the bed linen ready for me to wash and to dust while I hoovered. A trip out once a week for a few hours to local shops or our house lifted her spirits. These outings kept her mobility as good as it could be too. This might seem a very simple life for someone younger but it might be the envy of a person living in a care setting. Our greatest achievement as a family over the final 7 years of Mum's life was to keep her out of hospital. She spent just nine hours there on the day she died because she needed pain relief as her heart faded. It was the Sudden Death that she desired.

Some background about NAPA and me

NAPA is the National Activity Providers Association. It is a UK wide charity and membership organisation. We support care teams to enable older people to live life the way they choose with meaning and purpose. Our aim is for every care and support setting to be full of life, love and laughter.

Activity provision encompasses many aspects that contribute to quality of life including the need for mental well-being, social engagement, cultural stimulation via the arts and intellectual challenge. NAPA is developing new qualifications for activity providers and aspires to establish the role on a more professional footing.

For the past eleven years I have been the Director NAPA. In that time we have grown from a membership base of around 400 individuals to one of nearly 3000 mainly care home members.

My interest in this area of care was founded on the years I spent working in a Nursing Home as an Activity Coordinator and prior to that managing an activity based service working with Adults with Learning Disabilities living in community based homes. I am passionate about training and development and struggled to gain adequate qualifications in this field myself as none existed. I completed the only formal training course run by NAPA in the past, and now defunct, a City & Guilds 6977 in Therapeutic Activities in Care Settings. The most useful courses I have completed since then have been an IL&M Certificate in Performance Coaching and the Certificate in Preparation for Teaching in the Life-long Learning Sector.

During my time at NAPA I have had the good fortune to work with hundreds of dedicated people in the care sector including activity specialists, home managers, carers, chief executives, key influencers and many more. I have learnt something new every day and continue to do so.

The World Health Organisation defines Healthy Ageing as

“A state of complete physical, mental and social well-being not merely the absence of health”

the World Health Organisation defines Active Ageing as

“The process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age”

My observations in more detail

Activity provision in care settings in the UK has come a long way since NAPA was formed in 1997. At that time the role of Activity Coordinator was relatively new. Those who became members of the Association then were mainly working in isolation, frequently part time or sharing a carer/activity role and poorly supported. The concept of activity centred largely on entertainment and large group activities. A programme of activities might be displayed and if a resident chose not to attend it was seen as their choice regardless of whether the offer met their needs or appealed to the vast range of interest or leisure pursuits across those they cared for.

Moving on nearly twenty years we have a different picture. Care providers, regulators and society are beginning to recognise that well-being and a good quality of life are only achieved by meeting **all** the needs of an individual and not just personal care or clinical needs.

The challenge for many care providers is how to move the model of care to this more holistic approach. The culture change expected of care teams is a significant one and perceived by some as almost unattainable.

NAPA believes that one of the routes to change is by establishing the role of activity specialist in every care setting with the skills to support the care team to understand the unique needs of every resident. We often compare the role of the chef to that of activity specialist. A chef will be employed because they have training and skills to provide the right nutrition for every resident to thrive but they do not routinely support every resident to eat a meal. Using this analogy an activity specialist needs to be skilled and trained in their area of expertise and have the ability to share it with those that do interact with the resident twenty four hours a day.

In recent years, to support the development of these specialist skills, NAPA has successfully established two nationally recognised QCF qualifications which now offer a career pathway for activity providers. Our challenge now is what do we do next?

The aim of my travelling Fellowship was to compare what 2 other nations are doing to provide training and support for activity specialists with what happens in the UK. Both Australia and the USA appear to have more established and advanced career pathways and qualifications than the UK. NAPA has now established the first QCF recognised formal qualifications in this field in the UK along with the embryo of a registered profession. We are seen as the 'thought leaders' in this specialised area of care who are setting the standards. I believe we are at a crossroads now when looking at training and I wanted to explore what others have done to help us decide the best way forward.

I hoped to develop a sustainable strategy to guide the work of the charity, and care providers, based on the best practice developed by other international experts. I also hoped to build working relationships with other bodies and training organisations that could help sustain the development of activity provision across the UK and internationally in the future.

This report is based on my personal observations of ten care facilities in the USA and thirteen in Australia. I also met with nineteen key influencers, gave a presentation in the USA and led a

workshop in Australia. I did not set out to collect statistical data or to generate an academic research paper rather; I wanted to gain a sense of how activity provision looked in comparison to the UK.

I wanted to know how they addressed the lifestyle and leisure needs of the people they cared for. I was keen to talk to grass root activity providers to ascertain their perception of their role, what training they had had and what they felt they needed to do their job well. I also connected with creative arts professionals to understand the part they played in supporting activity provision in care settings.

I was fortunate that the care providers I approached were willing to be open and transparent. They responded to my request to visit a range of settings covering urban, suburban and rural locations and accepted that I didn't want to just see their top rated settings but a cross section that was representative of the facilities they ran.

In most cases I was able to book an appointment to meet a senior member of the team to gain an overview before being escorted around the facility, usually by the activity staff. This gave me ready access to frontline workers and enabled me to listen to their individual stories and views of their role. In many settings I was introduced to their creative arts specialist too. I was also able to meet with some training institutions and training providers who readily shared their knowledge with me.

"The difference between what you want and what you get is what you do"

Baroness Karen Brady CBE

- Lifestyle and health are inseparable

The unequivocal message of the past decade to the general population has been the impact that lifestyle has on our health. Not just around good nutrition and physical activity but in all aspects of mental health and well-being. The message should be no different for those that are cared for at the end of life and need some support to live a healthy life of quality and contentment.

In February 2016 the British Geriatric Society wrote this in response to the British Medical Association when they suggested withdrawing GP support from care settings in the UK. *"There are over 400,000 people living in nursing and residential homes in the UK. They generally have very complex health and care needs, which require skilled support not just from doctors, but from a range of other health and care professionals..... We must ensure that care home residents can continue to access the health care services they need. We call on the BMA and GPs to ensure that, in protecting the future sustainability of their services, they do not classify care home residents as anything less than full members of society, with the same healthcare entitlements as the rest of us."*

I was truly shocked when I read about the BMA proposal. From the first of my visits to the last, in both countries, I was struck by the level of integration of clinical and social care that was an accepted 'norm'. The care teams commonly comprised of a range of health care and well-being professionals – nurses, occupational therapists, physiotherapists, social workers, activity specialists - who all seemed to recognise the need for a multi-disciplinary team to meet the residents needs

fully. In the USA all the settings had a named Medical Director attending regularly. I even encountered full time Physicians Assistants in one setting.

Funding models varied from wholly insurance based and insurance paid by the state for rehabilitation but not care to private funders and not- for- profit organisations that subsidised costs. Attracting Federal, State or insurance funds was invariably dependent on completing detailed Assessment Forms for individual residents that were reviewed and submitted 3 or 4 times a year. Goal setting in agreement with individuals was common. Inevitably the Care Plan was the critical document that provided evidence to support the Assessment. All care professionals recognised the importance of both the comprehensive Care Plan and the Assessments as funding was dependent on them.

In the UK we have a distinct lack of integration between health and social care which impacts on those living in residential facilities. This leaves care teams unsupported by the skills and knowledge held by health care professionals. From what I witnessed this skilled input leads to a markedly different attitude towards Care Planning. In many cases assessment, evaluation and goal setting were routinely in place and a drive to maintain skills and abilities of the residents was paramount. Teams seemed to work towards a common aim for an individual recognising that maintaining mobility and avoiding aids like hoists was better for everyone including the carers. On the negative side this promoted a rather medicalised model of care that left little room for homelike lifestyles particularly in most of the USA facilities that I saw. The Australian homes generally were broken down into smaller units and few felt like hospital wards although some had rather sterile corridors and less engaging décor than can be found in the UK.

In both countries visited I had read about initiatives to introduce household style models of care and managed to go to one or two on my travels in each country. This model moves away from institutional ward type buildings and practices and aims for person centred care in environments that replicate a lifestyle at home. In the UK this has been the preferred model for some time and most new builds and many refurbishments have single occupancy bedrooms, comfortable living areas and more intimate dining spaces. The challenge for all 3 nations is how to adapt the culture of care to this more flexible way of working that gives the resident a voice and choice and control over how they spend their days. Managers in all three countries have told me that the activity provider can be a key contributor towards this culture change given the right support and the skills to influence the teams around them.

“We think our job is to ensure health and survival. But really it is larger than that. It is well –being. And well –being is about the reasons one wishes to be alive”.

Atul Gwande – Being Mortal (A book that everyone involved in care should read)

In the overseas settings I visited the activity teams seemed to be more valued and recognised for their contribution to both well-being and health. Equally during training sessions that I led in both countries I recounted some UK challenges for activity specialists such as lack of support from care teams, failure of care teams to carry out pre- planned activities in their absence, little effort made to encourage conversations, to name but a few. From the students responses these were common

concerns shared by activity teams across the world. The difference in the USA was that the Activity Department invariably constituted a team of staff who supported each other to deliver programmed group and one to one activities with very little connection with or support from the nursing aids/carers. In Australia I saw more carers supporting activity and more engagement with the activity staff who were generally a smaller team or solo provider. Generally in the UK, with some notable exceptions, the settings are more homely but the care teams still struggle to recognise meaningful engagement as part of their role and the activity providers feel isolated and unsupported in their attempts to bring life, love and laughter to the residents.

- Training and formal qualifications do make a difference

The School for Social Care Research (NIHR) Report 2014

“A lack of professional recognition may be one factor that contributes to the perpetuation of the perception that social care work is of low status. Certainly, in the light of ever- changing regulations, knowledge around social and medical care and evidence relating to certain practices in care homes and the length of time in role, it would appear to be a shortcoming in the system that continued learning is not a mandatory requirement.”

Katherine Orellana, Gerontologist

Most settings had an activity team led by a suitably qualified person who was recognised as an equal peer and a key part of the team by other health care professionals. In the USA they often carried the title Director of Activities although I also encountered Programme Manager, Lifestyle Team Leader and Engagement Team. Many held a degree in Recreational Therapy. In Australia Diversional Therapists (DT) are recognised health care professionals. Not all care settings in Sydney and Adelaide had a DT but they all had a skilled person in the lead role that had a nationally recognised Certificate 4 in Leisure and Health as a minimum.

In the USA New York State is not alone in requiring at least one of the activity team to be a Certified Therapeutic Recreation Specialist. A CTRS is expected to complete CPD in order to retain their qualification.

I asked activity team members how they had gained their qualifications. Some had gone straight from college to university and elected to do a degree course in Recreational Therapy although none had planned to work with older people at the time. Others had come into this work later in life but had related degrees in topics such as Psychology. Several Activity Directors had come into the role as Activity Assistants and had self -funded a degree course or CTRS, in their own time, in order to advance their career. I got the impression that people expected to pay for their own study if they wanted to progress. Many were happy in the Activity Assistant role as they enjoyed being ‘hands on’ and did not want managerial responsibilities. They did all value being part of a team and struggled to grasp the concept that in the UK they would likely encounter a sole person in the role.

In Australia I was struck by a comment from a senior manager who said they would not interview anyone in an Activity Leaders role who did not already have at least a Certificate 4 in Leisure and

Health. This was the most commonly held qualification for those that were not degree qualified in Diversional Therapy. DT's in Australia are nationally recognised with the same status and pay scales as other allied health care professionals. Both DT's and Cert 4 qualified people can join the Diversional Therapy Association of Australia. In discussions it was clear that it was accepted practice to gain qualifications and that an employer would encourage and support talented people. Although most were expected to study in their own time they would attract a pay rise once qualified and may well seek a new job in a more senior role. CPD was also seen as usual practice and the employer would support this through formal supervision and the appraisal process.

In the UK we have no equivalent degree level course. NAPA has been instrumental in developing recognised qualifications with an Award at QCF Level 2 and a Certificate at QCF level 3. NAPA also offers training to gain these qualifications but had to develop a cohort of markers and assessors in order to do so as none existed.

“In many care homes, the introduction of activities coordinators has had a positive impact on the quality of life of residents, although there is great variation in implementation and outcomes of this role. With the right skills and resources, the activities coordinators are an invaluable resource to challenge accepted practices and embed new and innovative ways of thinking around engaging and stimulating older people, regardless of their physical and cognitive abilities”. Review into the Quality of Life and Care of Older People living in Care Homes in Wales 2014

I am very keen to monitor the progress of an innovative project instigated by a major care provider group in South Australia. In brief they have implemented a pilot scheme to establish a well - equipped gymnasium into each of their care homes. Apart from appointing a highly motivated and skilled project leader and working on an evidence base generated by a very knowledgeable nurse they have retrained a number of activity staff to be fully qualified fitness instructors. The advantage of using these activity staff is that they already know how to motivate older people and they understand the culture of care too. The results so far are really promising with a number of residents regaining levels of independence and working towards goals they have set themselves. The ultimate aim is for everyone to be as fit and healthy as they can be and every sudden death will be celebrated as an achievement.

In the UK we have to refer a sudden death to the Coroner as we seem to expect people to 'fade away' under medical supervision.

- All care professionals identified a lack of training around leadership in the care sector

The Independent Commission on Dignity in Care (2012) made recommendations aimed at tackling the underlying causes of poor care of older people in care homes and hospitals. One was that “hospitals and care homes need to embrace a devolved style of leadership that values and encourages staff and respects their judgement. This means enabling staff to do the right thing for the individual patient or resident, not simply to follow process.”

Whenever I encountered an activity worker with a degree or qualification I asked them what knowledge or skill sets they thought were missing from their formal training. Every one of them identified leadership skills. When I explored this it transpired that none had realised the challenges of working with older people and as part of a larger team of care workers in residential settings. For the allied healthcare professionals their training and work placements had been mainly in hospitals and health care settings that bore little relationship to care home settings. Even those with activity specific qualifications recognised that these were broad based qualifications that could be applied in a range of settings from child care to penal institutions. This reinforced my view that the older peoples' care sector brings a unique set of challenges when attempting to share knowledge and influence practice. I know that some UK care providers have experimented with employing physiotherapists with variable success and it usually flounders when the health specialist fails to motivate the care team following an assessment of needs for an individual.

Some of the staff I talked to did not seem to recognise, or understand, the difference between management and leadership. Most could define a good leader within their care setting but assumed they were also 'the boss'. When pressed they could identify a colleague or peer that was a natural leader but commonly felt they lacked a position of influence to change culture. Many of the activity staff I met were naturally charismatic and highly motivated people and with some more knowledge around leadership could have had even more influence in their care settings. In my experience this is particularly relevant in the UK where we are trying to move away from process and task driven care to more empowered care teams. In both the USA and Australia the activity provision was enhanced by having teams of activity staff in varying capacities from Activity Assistant to Activity Director. They not only supported each other but could see opportunities for career progression and the Directors could nurture the leadership skills in their team members.

- Creative arts professionals can support quality activity provision if enabled to do so

Activity providers in all three nations seemed to value the knowledge and skills that specialist creative arts professionals could bring to their work. A good number of settings, particularly in the USA, routinely included artists in their programmes and in some cases they were permanent employees. More commonly they were sessional workers who were booked on a fairly regular basis which enabled them to get to know the client group and tailor their work to suit. Care settings that offered mixed provision of assisted living and residential style care were more likely to have dedicated artist studios where a range of arts and crafts could be offered.

From my conversations with grass root activity providers it was apparent that in most cases the artists would work with fairly large groups particularly for music and dance based arts. It was less common to hear of person centred planned art activity to meet an individual's needs or for them to work with a small hand-picked group although there were one or two notable exceptions. In Australia I saw slightly less evidence of visiting artists but where they were engaged they were clearly valued and seemed to be seen as part of the team. In one setting the visiting musician had been made aware of some of the residents goals too.

In the UK there seems to be a growing recognition of the value of a skilled artist but a reluctance or inability to commit resources to fund their work. NAPA has been involved with a number of

initiatives to promote the use of skilled artists to work alongside the activity and care teams to support them to engage more through the arts.

It can be a challenge in the UK to find artists of the right calibre and skill sets. In the USA the National Centre for Creative Ageing is a representative body that brings together artists of many persuasions and skills. The Australian Creative Arts Therapies Association fulfils a similar role. Moves are afoot in the UK, largely thanks to the Baring Foundation, to bring together various specialists creative arts based bodies but as yet no single organisation exists that care providers could look too for guidance.

“In addition to creative expression, the arts offer a whole range of personal benefits for older people themselves and to the wider community in its relationship to older people. It is even possible that use of the arts could decrease expenditure for the NHS. As in other areas of the arts it is difficult to quantify these social effects and to put an economic value on them. However the current economic climate makes it even more important to try to do this where possible and there is a need for more rigorous evaluation”

Ageing Artfully – Baring Foundation Report -Older People and Professional Participatory Arts in the UK - 2009

- **Sharing international knowledge benefits everyone**

I have never doubted the value of sharing, talking and working together as a route to better practice. My travels highlighted for me that we can learn from each other the world over. With modern communications it is just as easy to share with someone 10,000 miles away as it is the person sitting next to you. However, nothing can replace the relationships that develop when you meet and get to know people, see them in their own environment and swap experiences and stories.

I was struck by the similarities of personal qualities I saw in the activity providers on opposing sides of the world. The skills, knowledge and qualifications vary widely across the 3 countries but the ability to walk in someone else's shoes, think laterally, be flexible and care a lot were common to all. Generally they have a thirst for ideas, want to improve ways of working and to support each other with a generosity of spirit I have not seen elsewhere. NAPA strives to meet these needs in the UK and will now look to forming an international network to bring together others who share the passion.

Conclusion

Activity providers are specialists and, in the same way that a chef has specific training and skills, they need formal qualifications to support them to do their work well. Qualifications should be readily available from a basic level, minimum requirement through to a degree level course. Training and development of leadership skills is a neglected area for those who work in the care sector. My research showed that it is vital to know how to support and lead a care team and many professionals said it was a major gap in their formal training. Greater attention must also be paid when Care Planning to link health, well-being, lifestyle and leisure and not to treat each area in

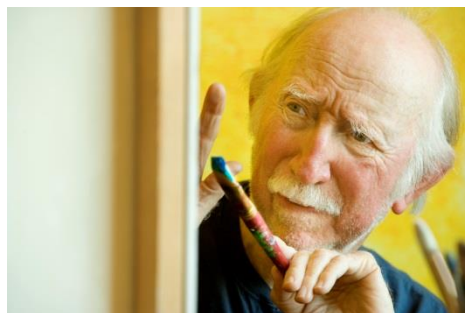
isolation. In the UK we currently have a number of initiatives to integrate health and social care better. I believe the care sector should consistently seek the support of health care professionals and creative arts professionals. Even if it is not initially forthcoming we need to raise the profile of the need for this level of skilled support to enhance care.

The term Sudden Death evokes a response and stimulates a discussion whenever I raise it. I will continue to challenge accepted thinking about end of life care and out-dated attitudes that some people are beyond meaningful engagement.

The knowledge I gained on my travels far exceeded my expectations. I had the opportunity to discuss, in depth, the curriculum content of training courses in a way that I could not have achieved from just reading a syllabus. Being given the time and funds to witness the range of different ways of working in a variety of care settings was invaluable. Talking to individuals about their training has already shaped my views on leadership. I have a much better understanding of the cultural and funding differences between the three nations and how that impacts on the care provided. I now have a network of contacts just as keen as I am to set up a worldwide support network. An unexpected consequence, but one encouraged by WCMT, was the chance to really think about what I was seeing and hearing - it is hard to find the time and space to do this in my day to day work : I will be eternally grateful for that and I hope many activity providers and older people will benefit as a result.

What NAPA will aim to do next

- Continue to be seen as the keeper of the content of, and quality of, qualifications around activity provision to ensure standards are set and maintained.
- Work with an academic partner to develop a degree level qualification in Activity Provision
- Work with an academic partner to develop a model for accessible leadership training
- Continue to promote the role of an activity specialist as a leader in their field of expertise
- Encourage care settings to connect more with creative arts professionals
- Develop an international network of like- minded organisations to share knowledge and skills
- Be more confident in our stance to drive home the link between health, well- being and the need for purposeful and meaningful engagement throughout life until the very end of life.



Supporting Organisations

I am truly indebted to the following care facilities, organisations and people for their generosity of time, knowledge and hospitality.

USA July 2015

Sharon O'Connor, Administrator, Iona Wellness Centre Washington DC

Julieta Holguin, Leading Age

Jessica Peters, Therapeutic Recreation Supervisor, Goodwins, Washington DC

Jay Virella, Director Therapeutic Activities, Amsterdam Nursing Home, New York City

Megan Bevan, Director of Therapeutic Recreation, Jewish Seniors Foundation, Washington DC

Deb Gibson, Activities Director, Brooke Foundation, Olney, Maryland

Jason Gottschalk Rockville Campus, Rockville, Maryland

Megan Tyler, Director of Activities, Aaron Manor Fairport, Rochester

Shelley Evans, Director of Activities, Music Therapist, Board Member for NAAPS, De May Living Centre , Finger lakes

The Activity Teams, Rochester Regional Healthcare Therapeutic Recreation Meeting

Deborah Richardson, Activities Director, 80th Street Residence, New York City

Joan Coenig and the New York Memory Centre, Brooklyn

Gary Glazner, Poet and Board Member Centre for Creative Ageing, New York

Australia November 2015

René Smith, Diversional Therapist, Health Strong, Sydney

Colin McDowell Environmental and Lifestyle Coach, Uniting Care, Sydney

Shannon Sladen, Leisure and Lifestyle Coordinator, Uniting Care, Sydney

The Marion, Uniting Care, Leichhardt, Sydney

Quong Tart, Uniting Care, Ashfield, Sydney

Annesley House, Uniting Care, Leichhardt, Sydney

Tracey Clark, Director Allied Services, Sir Moses Montefiore Jewish Care Centre, Sydney

Margie Kennard, Executive Officer, Diversional Therapy Association Australia

Loretta Holder, Diversional Therapist

Daniela McIntosh, Senior Dementia Consultant, Hammondville, Hammond Care, Sydney

Rebecca Matthews, Head Teacher, TAFE, Western Sydney Institute, Sydney

Nicole Peel. Lecturer in Therapeutic Recreation at Western Sydney University

Jackie Quirk, Red Leaf Training, Sydney

Rod Escobar, Team Leader, Memorial Hospital Day Respite Centre, Sydney

Renee Rizzo, Senior DT, Liverpool Hospital Brain Injury Unit, Sydney

Andrew Larpent,OBE, Chief Executive Officer, Southern Cross Care, Adelaide, S Australia

Jo Boylan, Operations Director, Southern Cross Care, Adelaide, S Australia

Kate Kameniar, Wellness and Lifestyle Coordinator, Southern Cross Care, Adelaide, S Australia

Meg Wemmer, Quality Manager, Southern Cross Care, Adelaide, S Australia

Bucklands Lodge , Residential Care Centre, Southern Cross Care, Adelaide, S Australia

The Pines and West Beach, Residential Care Centres, Southern Cross Care, Adelaide, S Australia

Bev Cardoza, General Manager, Philip Kennedy Centre, Southern Cross Care, Adelaide, S Australia

Megan Corlis, Director Research and Development, Helping Hands, Adelaide, S Australia

Doreen Bond House, Helping Hands, Adelaide, S Australia

Julie Cartwright, Lifestyle Manager ,Barossa Village, Southern Cross Care, Adelaide, S Australia

Maggie Beer, Celebrity Chef and Maggie Beer Foundation

Dr Kay Price, Associate Professor, School of Nursing and Midwifery, University of South Australia

Lyn Bartram, Facility Manager, Kapara Care, ACH Group, Adelaide, S Australia