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Coffee, Cake & Culture: Evaluation of an art for health programme for older people in the community

Brenda Roe
Evidence-based Practice Research Centre, Faculty of Health & Social Care, Edge Hill University, Lancashire, UK; Personal Social Services Research Unit, University of Manchester, Manchester, UK

Sheila McCormick
Performing Arts, Faculty of Arts & Science, Edge Hill University, Lancashire, UK

Terri Lucas
Whitworth Art Gallery, University of Manchester, Manchester, UK

Wendy Gallagher
Whitworth Art Gallery, University of Manchester, Manchester, UK

Andrea Winn
The Manchester Museum, University of Manchester, Manchester, UK

Sophie Elkin
Irwell Valley Housing Association, Manchester, UK

Abstract

Arts for health initiatives and networks are being developed in a number of countries and an international literature is emerging on the evidence of their benefits to people's health, wellbeing and quality of life. Engagement in cultural and creative arts by older people can increase their morale and self-confidence and provides opportunities for social connection. Museums and galleries are increasingly required to justify their expenditure, reach and impact and some are working in partnership with local councils, hospitals, schools and communities to improve access to their collections. There is a body of literature emerging that describes such initiatives but empirical evidence of their benefits is less developed. This article reports an evaluation of an art for health initiative – *Coffee, Cake & Culture* organised and delivered by Whitworth Art Gallery and Manchester Museum in 2012 for older people living in a care home and a supported living facility. The study has identified the benefits and impacts of the arts for health programme and its

Corresponding author:
Brenda Roe, Faculty of Health & Social Care, Edge Hill University, Ormskirk, Lancashire L39 4QP, UK.
Email brenda.roe@edgehill.ac.uk

feasibility for older people, with or without diagnosed memory loss – dementia, living in a care home or supported living facility and their care staff. The findings demonstrate there were benefits to the older people and their care staff in terms of wellbeing, social engagement, learning, social inclusion and creativity. These benefits were immediate and continued in the short term on their return home. The majority of older people and care staff had not previously been to the art gallery or museum and the programme encouraged creative arts and cultural appreciation which promoted social inclusion, wellbeing and quality of life. The programme is feasible and important lessons were identified for future planning. Further research involving partnerships of researchers, arts for health curators, artists, care staff, older people and their families is warranted.

Keywords
older people, care home, community, arts for health, dementia

Introduction

Public policy promotes 'active lives' for ageing populations so that older people can maintain their independence, continue contributing to society and add quality to their lives (Brown, Bowling, & Flynn, 2004). The notion of citizenship with older people having rights to independence, participation, self-fulfilment, care and dignity within their communities also form part of the active ageing agenda (World Health Organisation (WHO), 2002). The European Year for Active Ageing 2012 endorsed these policies and included plans for age friendly environments and cities, with accessible public buildings, infrastructure and transport as well as promoting physical exercise, social engagement, inclusion and justice for older people and ageing populations (WHO, 2012a).

Ensuring a positive life experience for older people is about promoting their health and functional capacity, their social participation and security which contribute to overall quality of life and wellbeing (WHO, 2012b). Loneliness and lack of social interaction can affect the quality of life of some older people (Scharf & de Jong Gierveld, 2008; Victor, Scambler, Bowling, & Bond, 2005).

Older people are more likely to live with a number of long term conditions, resulting in loss of function, disease, frailty and vulnerability over time requiring support and help with care (Phillips, Ajrouch, & Hillcoat-Nalletamby, 2010; Roy & Giddings, 2012; WHO, 2005). The majority of older people continue to live in their communities, living longer and with long term conditions although some require additional support of extra care or institutional care. For example, there are estimated to be 700,000 people with dementia in the UK (Department of Health (DH), 2009) with most having at least one other co-morbidity (National Audit Office (NAO), 2007), which can result in complex psychological and physical needs at advanced age (Sampson et al., 2008). A third of people with dementia live in care homes (Knapp et al., 2007, p. 237), with an estimated 64% of residents in care homes having some form of dementia (Alzheimer's Society, 2012). Only around 43% of people with dementia have a confirmed diagnosis (Alzheimer's Society, 2012).

Residents' mood correlates with reported quality of life (Hoe et al., 2009) and people with dementia in care homes have significant levels of unmet needs, relating to lack of stimulating daytime activities and company (Hancock, Woods, Challis, & Orrell, 2006; Mozley et al.,

2004). Physical and safety needs of residents may be met but not necessarily their social needs with higher levels of depression and inactivity prevalent (Abrams, Teresi, & Butin, 1992; Mozley et al., 2004). Arts and creative activities form part of social engagement/involvement and social prescription for health, wellbeing and quality of life within communities. Some care homes but certainly not all offer a range of purposeful activities with anecdotal evidence of benefit, often by staff (Moos & Bjorn, 2006) and are potential measures of care home quality (Mozley et al., 2004). Arts and creative activities have the potential to improve health, wellbeing and quality of life for older people in care homes and address inequalities within this vulnerable population (Belfiore, 2002; O'Neill, 2010; Staricoff, 2004).

The past 10 years has seen a development in the arts for health agenda, recognised by Arts Council England (2007a,b) and the Royal Society for Public Health with international conferences, museum and gallery in-reach and out-reach initiatives, art installations in hospitals and singing projects (Belfiore & Bennett, 2008; Bungay, Clift, & Skingley, 2010; Chatterjee, Vreeland, & Noble, 2009; Froggett & Little, 2008; Froggett, Farrier, & Poursanidou, 2011; Health & Culture, 2011; O'Neill, 2010; O'Shea & Leime, 2012; Rosenberg, 2009; Rosenberg, Parsa, Humble, & McGee, 2009; Royal Society for Public Health, 2012; Stickley, 2012; White, 2009). Historically there has not been an evidence base for identifying the benefits of cultural arts for health initiatives with most focus being on the content and delivery of arts activities or therapies (Camic & Chaterjee, 2013; O'Neill, 2010; Staricoff, 2004). However, there is an emerging body of knowledge which is seeking to establish the impact and benefits of culturally based arts for health projects on wellbeing and quality of life as part of social capital, engagement, justice and public health (Clift, 2012; Rosenberg, 2009; Rosenberg et al., 2009; Staricoff, 2004).

Three Cochrane systematic reviews specifically relate to therapy and people with dementia (Vink, Bruinsma, & Scholten, 2011; Woods, Spector, Jones, Orrell, & Davies, 2009; Woods, Aguiire, Spector, & Orrell, 2012). Ten trials not specific to care homes on music therapy (7 actively involving participants individually or group) concluded research was promising, could diminish behavioural and cognitive problems and improve social and emotional function (Vink et al., 2011). Reminiscence therapy for older residents in care homes located five trials, with activities in groups or individually by qualified health professionals found some evidence to suggest effective in improving mood with effects not well understood (Woods et al., 2009). The third review was also delivered by trained health professionals using cognitive stimulation, positive reality orientation to improve cognitive functioning in people with dementia and concluded consistent evidence of benefit (Woods et al., 2012). These systematic reviews were targeted as therapy by trained staff as treatments for dementia. A further systematic review on life story institutional care of people with dementia located 28 intervention studies that used quantitative and/or qualitative evaluations. The study designs were not specified and overall effectiveness could not be synthesised due to the disparities of designs, methods and data (Moos & Bjorn, 2006). These reviews and trials were specific therapy targeted at people with dementia and tended to be of low quality without evidence of cost effectiveness. Two further systematic reviews looked specifically at cognitive leisure activities or physical leisure activities in preventing dementia in community populations (Stern & Konno, 2009; Stern & Mumm, 2010). Physical activities appeared beneficial. The arts and health activities are broader creative enterprises not intended as therapy but may be therapeutic (Stickley, 2012). They include performing and creative arts and humanities activities, such as music, singing, dance,

reading and poetry groups, creative writing, life story narrative/reminiscence work, painting, collage, pottery, sewing, knitting, woodwork or gardening. A strong evidence base to inform such creative arts activities is lacking, although they feature in arts for health initiatives and programmes. Rigorous evaluation and research evidence is required to support their continuing development (Cameron, Crane, Ings, & Taylor, 2013; Camic & Chaterjee, 2013; Clift, 2012).

Older people in care homes are more likely to have restricted activities of living, impaired mobility, incontinence and depression (Knapp et al., 2007; Mozley et al., 2004; Netten, Darton, & Williams, 2005, p. 209). All of which can impair health, wellbeing and quality of life adding to their vulnerability and health inequalities. Meaningful activities, social contact and engagement are potential measures of quality care for older people in care homes (Mozley et al., 2004). Arts based activities and interventions have the potential to improve health, wellbeing and quality of life of these populations, address inequalities and social justice.

This paper reports an evaluation of an art for health programme by Whitworth Art Gallery and Manchester Museum, University of Manchester from June 2012 to November 2012. It comprised six sessions of supported and facilitated visits (involving 4 staff; arts for health programme manager, community out-reach curator, 2 from gallery visitor services and 2 artists) for older residents and carers from a local care home and supported living establishment. Residents attended with their project worker or activities co-ordinator and care staff for a 2 h guided, informative tour with creative activities and refreshments (see Figure 1 for summary details). It formed part of usual care and activities, although novel. The programme was part of the emerging work of the gallery and museum (in-reach and out-reach) with the community to promote access to their collections, share knowledge and learning, social engagement and participation in cultural and creative arts activities.

Methods

Aims

To identify the benefits and potential impact of an arts for health programme on the wellbeing of older people from supported living and care home populations.

To evaluate the feasibility of an arts for health programme for older people in supported living and care home in the community.

Design

Evaluation research using non-participant observation and semi structured group interview. The evaluation was independent of the arts for health programme and took place in parallel, June 2012–December 2012.

Participants

Participants comprised self selecting residents from a supported living facility and care home ($n = 17$; 8 and 9, respectively), their care staff and one relative ($n = 11$). Staff from the museum and gallery who delivered the programme ($n = 4$) participated in the final evaluation group interview along with the supported living project worker, supplemented

COFFEE, CAKE AND CULTURE

The Manchester Museum and Whitworth Art Gallery run a monthly programme for elderly people in supported housing or care homes, individuals with dementia and their family members or care partners. Coffee, Cake and Culture provides a forum for dialogue through looking at museum objects and art. There are opportunities to handle objects and make art. Specially trained Museum educators highlight themes, artists, and exhibitions during an interactive program in the Museum's galleries and classrooms.

1. Fri 22 June 10.30am –12pm and 2-3.30pm at the Manchester Museum

THE MANCHESTER GALLERY

In a tour around the Manchester Gallery find out what is the link between a red deer antler, a box of beetles and Smithfield Market. Manchester has a fascinating history and the gallery uses objects to explore the relationship between the Museum and the city's history. Followed by presentation from a curator, handling and looking at objects and artefacts from the collection and discussion. Sharing of knowledge and information.

2. Fri 6 July 10.30am –12pm and 2-3.30pm at the Whitworth

WE FACE FORWARD

Embrace all that you don't know about the art, culture and creativity of West African artists today.

An indoor forest populated by wooden figures, suspended sculptures, African totems and multi-coloured diamonds, spilling out into the neighbouring park. Sharing of postcards and promotional handouts from past, current and future exhibitions and handling of rope and textiles.

3. Fri 24 August 10.30am –12pm and 2-3.30pm at Manchester Museum

LIVING WORLDS Gallery

Living Worlds explores the connections between all living things, including us, and shows how we can all shape the future by the choices we make. Then work interactively as a group to make up a story based on animal exhibits from the Museum's collection.

4. Fri 7 September 10.30am –12pm and 2-3.30pm at the Whitworth

WE FACE FORWARD

A visit to our gallery and see the wonderful works of art, collage and collections from West Africa. We invite you to share your thoughts and make a collage with an artist that reflects your story or interests.

5. Fri 12 October 10.30am –12pm and 2-3.30pm at the Museum

TOUR OF THE VIVARIUM

Enjoy a tour of the Museum's vivarium with an opportunity to meet the live animals and find out about the museums ongoing conservation work.

6. Fri 2 November 10.30am –12pm and 2-3.30pm at the Whitworth.

HOCKNEY TO HOGARTH; A RAKES PROGRESS

The art of visual story telling. Meet artist and printmaker and make a print of your very own.

Figure 1. *Coffee, Cake & Culture* arts for Health programme sessions and content guide.

by written comments from an artist and activities co-ordinator of the care home ($n = 7$). Participants from the supported living facility and care home were convenience samples who chose to attend the arts for health sessions.

Data collection

Non-participant observation was undertaken and field notes were recorded during and following each session by one member of the research team. Sessions were held once a month during the six months of the programme. Care home participants attended the morning session and supported living participants who attended a duplicate session in the afternoon. Spradley's framework of nine dimensions of observation was used to collect and summarise the observation data and field notes (Spradley, 1980). The dimensions comprise; space, objects, acts, activity, event, time, actors, goals and feelings. Field notes recorded interactions and dynamics of the group activities and events that took place. Data were collected for 11 of the sessions and all the planned visits and activities for both the gallery and museum were included. One session was rearranged as the care home residents were unable to attend on that particular day.

A month after the final session of the programme a group interview was conducted with gallery and museum staff and the supported living project worker. The group interview took the form of discussion, lasted about 1 h and was digitally recorded (with agreement). The interview guide included questions to elicit information on their overall impression of the programme and individual aspects (see Figure 2). These data were supplemented by written information from one of the participating artists and the care home activities co-ordinator who were unable to attend.

Ethical considerations

Ethics approval was obtained from the Faculty Research Ethics Committee. Project information sheets and informed consent forms were given to the residents by their lead staff – project worker and activities co-ordinator. Residents or their proxy gave informed consent/assent. No personal information or data were collected regarding residents and their identities were anonymous. Process consent was also used for each session by the respective lead staff with their residents.

Data management and analysis

Field notes were typed up following each session and a summary of each of session was made using the nine dimensions of Spradley's framework (1980). Content analysis was performed independently by two members of the research team reading individual sessions and across all the sessions using a constant comparison approach to identify key points related to the benefits and impacts of the sessions and feasibility of the programme. Where data from the dimensions overlapped these dimensions have been grouped and reported together. Data from the group interview and written notes were transcribed and content analysed according to each of the key questions (Figure 2). These data were also analysed independently by two members of the research team.

To assure the rigour and trustworthiness of the analysis, data were analysed independently by two members of the team who then discussed each of the themes

1. Overall impressions,
2. What worked best ?
In terms of; transport, organisation, individuals' roles, sessions (generally, specifically – aims/objectives), creative activities, social activities, benefits (residents, care staff, organisations – home/gallery/museum), resources.
3. What did not work so well?
In terms of; transport, organisation, individuals' roles, sessions (generally, specifically – aims/objectives), creative activities, social activities, benefits (residents, care staff, organisations – home/gallery/museum), resources.
4. What would you change, do differently – how and why ?
5. What would you keep – which and why?
6. In terms of impact – benefit,
Were there any in relation to health and wellbeing for residents? Care staff?
Health and wellbeing? or just wellbeing ?
How was this noticeable?
7. Were there any negative consequences to health or wellbeing for residents or staff attributable to their participating? If so, what were they?
8. Overall, what were the residents', care staff views of the programme – good, bad or indifferent?
9. From each of your perspectives, would you do this again, the same or different? In reach vs. outreach? Would other older people who could not attend the gallery/museum have benefited?
Thank you, is there anything we have missed that you would like to add?

Figure 2. Indicative questions and prompts for final group interview with staff.

identified and consensus reached by agreement. Findings from the observations and group interview were compared to establish overall consistency and data saturation. There was agreement between the findings from the observation and interview data.

Findings

Session and participants

All six sessions of the programme went as planned, except for one session (4), which was altered as the gallery picture store was not accessible (Figure 1). Eleven sessions were observed due to one session being cancelled by the care home and rearranged for another date. A total of 17 residents (8 care home and 9 supported living), 10 care staff and one relative attended the sessions. Four residents from the care home attended regularly along with their activity co-ordinator as did three residents from the supported living with their project worker. Only one other member of the care staff attended on one occasion while four care staff from the supported living regularly attended and they had the highest staff to resident ratio of 1:1. The staff to resident ratio for the care home was 1:5. Four staff from the gallery or museum regularly attended and delivered the programme supported by two artists

on separate sessions. Biographical information on visitors (residents and care staff) was not collected as they were considered members of the public attending the gallery or museum. First names were known to all visitors and staff and they were hand written on name badges that everyone wore to aid conversation. There was an even split between men and women residents attending from the care home while those for the supported living tended to be women with one man attending four sessions. Their ages ranged from 75 to 92 years (care home 76–92 years; supported living 75–88 years). At least two people from the care home and three from the supported living were in wheelchairs with others requiring the use of sticks, walking frames or staff assistance with walking. Half wore glasses, with one woman hard of hearing but not always wearing her hearing aid. Portable collapsible chairs were used, provided by the gallery and museum.

Impacts of arts for health programme and sessions

Acts and actors. Each session comprised a performance of acts and actors. The acts were I arrival, meet and welcome (at 25 min); II informative introduction to exhibition and collection (at 45 min); III refreshments, social interaction and creative activity (60 min) and finally IV depart and farewell (at 20 min). Acts II and III varied at each session depending on their content, exhibition, collection items and creative activity. Each act was of equal importance. Not all visitors (residents and care staff) had been to the gallery or museum before and they were unfamiliar environments. The gallery/museum facilitator staff being present to meet the visitors on arrival was agreed as important to welcome them and put them at ease, as was having the buildings accessible for people in wheelchairs or using walkers. On one occasion the disabled access had not been opened and visitors had to wait outside tin the rain for it to be unlocked (session 3). On another occasion visitors were dropped quite a distance away from the museum and had further to walk and negotiate access to the building (session 4). On departure, a taxi driver refused a visitor in a wheelchair passenger access and they had to be assisted out of the wheelchair into the cab. The apparent lack of regard or empathy by the taxi driver was a source of incredulity and anxiety for the facilitator staff (session 6). These events highlight the importance of adequate planning for each act to ensure visits run smoothly to plan, with sufficient time allowed for access, departure and moving within the gallery/museum environment.

The actors comprised: visitors (older people residents and care staff), facilitators (gallery/museum staff and artists) and observer (research team). The supported living had a high staff to resident ratio while visitors from the care home regularly had the lowest staff to resident ratio. The latter were supplemented by gallery/museum staff, and was vital to support, interaction and creative activities undertaken by each group. There were a few visitors from the care home and supported living who regularly attended the sessions/all of the sessions along with a few key staff. Residents were unable to attend subsequent sessions due to ill health, hospitalisation or having appointments with service providers they needed to keep. A care staff commented they encouraged other residents and staff to attend each of the sessions so they could all get some benefit although some of the older residents who were 'regulars' insisted on attending all visits (session 3). Some care staff had not been to galleries or museums before and these visits had inspired them to bring their grandchildren in the future.

The needs of visitors were apparent in terms of their mobility, use of wheelchairs, walking aids and assistance required; their vision (use of glasses), their hearing and

memory. Having sufficient staff to support visitors moving around the building, answering questions, responding to their needs, their interests and working with them on creative activities should not be underestimated. It was agreed the main skill for facilitators was the ability to communicate effectively; having a high staff/participant ratio vital, being prepared as well as flexible to allow for changing and differing group dynamics and individual needs also required. Care staff stated they thought the information was pitched right; 'not too high brow or dumbed down' and was facilitated by pre-planning the programme and sessions between gallery/museum staff and care home/supported living staff.

The facilitators needed to engage participants with collections and activities, share knowledge, present information, facilitate discussion, social interaction and engagement, answer questions as well as lead and support the planned creative activities. Two key observations noted that 'communication was respectful . . . unrushed and with dignity' (session 4). This level of respect was also evident in the following event;

> 'Later on A told me that D walked a while then asked if she could go to the toilet. She may have been too embarrassed to ask in front of the group. A (gallery staff member) thought, 'I cannot help her there' so brought her back to a care home staff member who went with her (session 4).

Space and time. The gallery and museum are public spaces, with the museum designed and built during the Victorian era and the gallery updated in the 1950s/60s with a more open plan design. Neither building was designed for older or younger visitors requiring use of wheelchairs, prams or pushchairs. Disabled access to the museum was not ideal, nor lifts or toilet facilities in either the gallery or museum. Both environments were in the middle of major refurbishment and access within their spaces to exhibition areas and quiet rooms was challenging. Time was required to negotiate, moving between different areas and staff support was essential. Two and a half hours were allocated for each of the sessions to allow time for each of the Acts with sessions generally keeping to time. During some of Act II presentations the noise levels from children visiting were high making hearing difficult and could vary, afternoons and school holidays in particular. While gallery/museum staff viewed this as a challenge to their presentations and planned sessions care home staff suggested their residents being engaged in everyday activities along with other visitors was positive and 'normal' experience and countered their usual days in their homes which could be quite isolated. So too, the journeys and rides in the taxis which prompted memories and interest. It was noted that exhibits and activities did encourage visitors' engagement with their personal and shared history. The programme prompted them to discuss their history and shared experiences as well as learning new information, participating in creative activities, making art works they could take home with them.

Goals, events, objects and activities. The overall aim or goal of the programme was to promote wellbeing for older people living in residential care in the community through cultural and creative arts activities by engaging with gallery/museum exhibitions and collections. All staff agreed the aims and objectives of sessions and overall goal of the programme were met. Care home staff stated;

> 'The sessions were beneficial and well structured, and the residents appreciated the human connection and social encounters more than the art and museum.'

The interactive encounters brought the best responses, holding a snake, a frog, etc. in the vivarium. A member of the gallery staff said;

> 'What really stands out for me was the animal interaction in the vivarium was amazing to see. To see their faces light up and their connection with something they never get to see in everyday life and to be able to hold and a touch a chameleon.'

It was also stated being able to create their art work was a source of pride. This was echoed by the print maker artist who stated that;

> 'The process of print making is a recall tool. It can assist in the activity of recalling and remembering drawing and is an aid to memory. People are positively surprised by their hidden talents. Many have not drawn for many years and it takes them back to earlier times, usually school days, focusing on memories of activities, places and people. ''I haven't drawn since school'' is a common utterance.'

This was also evident in the session when they recalled Belle Vue Zoo based initially on a key exhibit of the elephant. An artist also commented;

> 'The visitors relax through the creative process, have informal conversations and draw on memories triggered by the exhibits and creative activities. The creative process can be a bonding process.'

It was noted that the sessions involved visitors using their senses. The sessions were based on Anne Davies Basting's (2009) work encouraging the exploration of creative capacity as opposed to memory or recall of factual information to encourage positive feelings. Social engagement, creative activities, learning about the collections and history using movement, dance, imagination, touch, visual, audio and taste required use of senses. The print making session was popular as it was technical and creative. Care staff said:

> 'They still have them (prints) up in their rooms. The artists were very skilled communicators to inspire the visitors to be creative and hands on.' She went on to say 'they are nice people and the residents enjoy themselves. It is social and they are able to chat.'

Individual goals were also allocated to each session. For example, session 3 at the museum, the goal of the event was to encourage:

> 'visitors to enjoy the exhibition and exhibits, gain knowledge and understanding of how nature inspires us. Also, to enjoy being creative and making up a story together as a group that they are able to keep and read again.' (museum staff)

The programme included three sessions in the museum and three in the gallery (see Figure 1). Each session was discrete and so visitors could get something from attending just one session or the whole programme. A few residents attended all six sessions. The museum's Living Worlds gallery and tour of the vivarium allowed visitors to engage with a range of subjects, from the city they inhabit and combined history, to their connection with all living things and planet we collectively inhabit, to engagement with live animals. Other sessions, by comparison, engaged participants artistically and creatively with a range of activities examining artefacts from other cultures, to participating in story making, to making their own individual prints. Combined, the sessions in these two sites allowed participants to engage in activities that drew on their individual senses, memories and identities.

The objects used in each session varied according to the activity. In session one, for example, visitors explored their communal past, examining and interacting with material from the museum collection. The visitors handled objects including boxes of insects, cotton heads in a box, a beetle and tokens from Belle Vue Zoo. This allowed participants to examine their city's cultural, social and industrial past in a way that included them in that past. In the afternoon session, for example, visitors shared stories of their memories of Belle Vue Zoo (subsequently closed), especially the ride on an elephant which they had all experienced (session 1).

Session 5 on the other hand included handling and viewing live animals, such as lizards, snakes and frogs. In this session participants said they 'enjoyed the animals'. Only one person was wary and declined touching or holding them. Visitors looked in wonderment at the animals, one joked about having one in a sandwich. Several of the participants commented on the animals being 'beautiful' and 'gorgeous'. The reaction was universally positive with one participant commenting 'you are never too old to stroke a lizard'.

Over the course of the programme various activities occurred with varying levels of engagement. Most importantly, through the diverse range of activities the participants were able engage in a variety of sensory experiences. Visitors looked at or handled a variety of objects, in particular contexts, read exhibition materials, discussed them and took home materials to read and show others. In session 3, visitors worked with a facilitator creatively to produce a story using the group's imagination stimulated by a tiger and cheetah from the museum collection. Field notes commented on the group's ability to make comparisons, recall memories and express empathy through this activity.

Feelings. For the most part visitors expressed positive feelings about their experience of the programme using words and phrases such as 'lovely' and 'very, very nice' (session 6). A visitor in session 4 said she had not enjoyed herself and would not being attending again however she did so in a later session (session 4) and attended all six sessions. On several occasions visitors vocalised enjoying the visit and looking forward to the next one. The activity co-ordinator stated, 'I speak for all at the home . . . this has been the highlight of the last few months.'

Museum/gallery staff and artists 'were clear on what their roles were but they were flexible and responsive to meet the needs of visitors, in particular older people.' (gallery staff). It was noted that group dynamics differed between visits depending on who visited and what had occurred before their arrival at the gallery/museum, particularly in relation to people who have dementia.

> 'One visitor was quite anxious and needed reassurance and so having their own staff with them and having a high ratio of staff was good in this respect' (gallery staff).

Humour, banter, and innuendo factored in some of the sessions, as did an interest in contemporary events, such as the Diamond Jubilee and the Olympics 2012. Contemporary and historical events were contextualised highlighting participants' interest in current events as well as a sense of importance of the past.

Benefits, impact on wellbeing, feasibility of the sessions and programme

The ability of gallery/museum staff to be flexible and respond to older participants' needs was a recurring factor throughout the observations and group discussion. For example, the

physicality of these staff was acknowledged when it was noted that they knelt down to be at the same level as visitors to speak to them and maintain eye contact, while the care staff also knelt down so as to be at the same height as the visitors in wheelchairs (session 3).

In another session, the varying needs of participants became obvious when one visitor appeared disorientated and 'looked a bit bewildered at times' (session 4). It was also noted that sometimes, visitors needed reassurance that they were not on their own and that it must be disorientating being way from a familiar location. Staff noted that 'orientating people/visitors and saying where they are going and what is happening next is so important/vital.' (gallery staff). This was evident when two visitors sought reassurance about not being left alone (session 4).

As part of the final group interview discussions took place about the overall benefits to residents, staff and the gallery/museum. Care staff said;

> 'They loved it, getting out and being in normal society, being in the hustle and bustle, seeing other people was good and they liked the journey in the taxi. They enjoyed the learning, all really listened and their attention increased over the weeks, as they knew what to expect. It triggered memories, one resident was able to speak French and translate for everybody. No-one knew she could speak French. They enjoyed going out. They need to go out as living in a home is isolating.'

The benefits to health and wellbeing for the residents were hard to measure, although it was noted that one visitor;

> '...was really off and I was 50:50 whether to take her (on the visit). (She was) not good, confused, anxious but (we) had committed. Within half an hour of her arriving on the visit she was much better, focusing, listening – when we got back home, the staff noticed she was more perky. Before in the taxi she was anxious saying "we're going to crash", but once settled she loved it, (and asked) when are we going next?' (care staff).

Visitors retained the experiences and talked about them;

> 'The social values are important as orientates them and validates them as a person in the museum. They are part of a group. They would share their experiences and had different roles too, friends, visitor, creative role. The residents bonded well with each other and friendships among residents developed as had shared experiences.' (care staff).

The benefits to care staff were also identified;

> '(They) were sceptical initially, a lot had not been to museums before and definitely did not think why take an 86 year old woman to a museum, but (they) now realise it is really beneficial. They use the things made as a talking point to trigger conversations and memory. It gives them things to talk about with residents and it helps them bond with the residents – builds relationships. The staff saw the residents in a different context and in a different light. Not seeing the person in a care context but in a social context, staff do not always see them in "other" environment contexts.' (project worker).

Benefits to the gallery and museum were also identified, not least the feasibility of running arts for health programmes and how they should be developed in future but also in terms of

their working with older people, social engagement and capital, and not making assumptions, as this quote illustrates;

> '(We) learnt from the residents/visitors, for example the West Africa exhibition was very contemporary and included black artists. There were no adverse comments about the contemporary works and they were transfixed by the South gallery trees and the market stall. It reminded staff not to make assumptions about people's views. Humour was always a feature of the visits. It has given us ideas of how to run things in the future.' (gallery staff)

Feasibility of the programme, sessions and the future. The above findings indicate what worked well in the programme and individual sessions and identified benefits for visitors, staff and organisations: care homes, supported living, gallery and museum. Finally, looking at what did not work well and needed changing, the following comments and observations were made.

Gallery/museum staff said in future they would let their visitor services know the planned visitor routes so services staff could try and manage movement of people between rooms. This would help to control the space and encourage a balance between the public gallery space and quiet room.

The supported living project worker shared her anxiety before a visit wondering if a resident would settle if they had been a bit anxious beforehand, which is why a high staff: resident ratio is warranted. One participant cried/was tearful as it evoked memories of her husband who was no longer alive and she misses him. Visitors did at times need reassurance. Some visitors told frequent repetitive stories, and their care staff knew what these were. By the end of the programme so did the gallery and museum staff did too. As stated previously humour, banter, and innuendo were features as was an interest in contemporary events.

The group mentioned 'visitors liked, appeared to appreciate 'expressive touch' (compared to instrumental/care touch) and included gestures of holding a hand, touching an arm or shoulder. They thought this might be why the tactile sessions with the live animals and stroking some of the taxidermy animals were popular' (group discussion). All in the group discussion said they were committed to continuing – in one session a family member attended and she directly saw the benefit her mum was getting – 'she saw things in her she had not seen in years.' (project worker).

As previously noted transport was an important feature. Funding of transport (taxis) was agreed a consideration for the future and was available for the programme 'in house' to support in-reach into the gallery and museum. A strength of the programme was that each of the sessions were discrete and some visitors who were able and wished did attend all of the sessions while others could attend only one or a few. Consequently even visitors who attended once or a few times as acts II and III for each session were stand alone, they were able to gain knowledge, learn and engage with art and exhibits along with other members of the public also viewing the exhibitions. Six further sessions are planned, will be pre-bookable and open to a wider group of homes and supported living facilities for older people in the community. In-reach visits to the museum or gallery are feasible if people can attend but not all residents are able to. The approach proposed is to continue going to homes/residences initially (out-reach). The museum staff/community curator said: 'it is important to offer some out-reach for residents who cannot come in. Also, not all care

homes can organise or offer to support such visits/activities. So, there needs to be a balance of in-reach and out-reach for arts for health programmes.'

Discussion

Visitors comprised care staff and older people residents – most requiring use of a wheelchair, aids for mobility, vision or hearing. Care staff to resident ratio was highest for the supported living visitors and lowest for care home visitors, which was surprising as people in nursing homes tend to have greater needs and support for activities of daily living (Darton & Muncer, 2005; Netten et al., 2005). Having high level of support and 1:1 in some instances was advantageous to run the sessions and meet the needs of the visitors particularly as some had mild memory problems, although whether the older visitors had confirmed diagnoses of dementia was unknown to gallery/museum and research staff as the premise taken was that residents and care staff were attending the programme as citizens or members of the public, as such diagnostic labels were irrelevant (Rosenberg et al., 2009).

The overall aim and goals of the programme and sessions were to promote wellbeing through engaging with the collections/exhibitions, creative activities and social encounters facilitated by staff and artists. It was noted that living in a care home can be socially isolating and such trips were beneficial and enjoyable, in keeping with other studies (Cameron et al., 2013; Roberts, Camic, & Springham, 2011; Swindells et al., 2013). Benefits were not just limited to the visits but continued in terms of friendships between residents, care staff seeing older people in a new light because of social interaction and creative activity. Care staff remarked that the events and the artworks they created became a talking point with staff and family members afterwards and helped lift their mood and social engagement. Older people shared their experiences, knowledge and memories of events, places, times, which were positive and often took the form of storytelling, banter and humour. The programme focused on creativity rather than reminiscence, memory or recall, which for people with memory problems can be difficult and distressing (Bohlmeijer, Roemer, Cuijpers, & Smit, 2007). Sessions were designed around the senses; touch, vision, hearing, imagination and creativity and similar to other programmes evoked memories (Camic & Chatterjee, 2013; Chatterjee et al., 2009; MacPherson, Bird, Anderson, Davis, & Blair, 2009; Rosenberg et al., 2009). Only two residents had been to the gallery before; attending museums or galleries was not the norm for residents or care staff. This is similar to the finding of Chatterjee, Vreeland, and Noble (2009). The programme/sessions were enjoyable providing opportunities for learning, creativity and social engagement and the sharing of memories of places they lived, work they undertook and their families. The sessions allowed the residents, care staff and gallery/museum staff to come together as a group but also allowed individuals time to view or work alone, providing the best of both worlds. Studies of loneliness have found older people benefit more from being in groups than individual one to one (Scharf & de Jong Gierveld, 2008), which our study and that of Rosenberg (2009), also supports.

Accessing the buildings from taxi transport was difficult due to inclement weather and the disabled access not being open. The ageist attitude of a taxi driver was also noted. As 'an Age Friendly City' and Manchester's 'Valuing Older People' strategy (Phillipson, 2012; Valuing Older People, 2009), such occurrences should diminish. The buildings were undergoing major refurbishment and future access should improve for all visitors. High noise levels and low lighting in some spaces were a concern for gallery/museum staff but

care staff noted this was all part of the experience of being in the 'real world' for older people whose lives in the home could be socially isolating. Being able to mix in environments with people of all ages was considered beneficial and seen positively by care staff. Having, a separate session (act III) where creative activities took place in a quieter location was valued. Buildings, windows and green spaces have long been known to effect health, wellbeing and recovery (Gesler, Bell, Curtis, Hubbard, & Frances, 2004; Ulrich, 1984). It was also noted that if visitor services were aware of future visits they could manage the flow of people better through the public spaces to avoid excessive noise.

Feasibility of arts for health programme

The *Coffee, Cake & Culture* programme was feasible and deliverable with sessions and content planned between the gallery/museum staff and the homes project worker and activities co-ordinator. As each session was stand alone, older people and care staff who could not attend all of the programme but only individual sessions were able to benefit. This format differs to and builds on other arts for health programme initiatives (MacPherson et al., 2009; Roberts et al., 2011; Rosenberg, 2009; Rosenberg et al., 2009; Swindells et al., 2013) and means that older people can see the benefits of their creative activity within one session as opposed to over weeks, which is a traditional occupational therapy approach in institutional settings. The future plan is to continue offering the programme as universal pre-bookable sessions to a wide variety of care homes/supported living within the community rather than specifically targeting individual homes. Establishing universally available cultural arts programme for the wider community is in keeping with new public health (O'Neill, 2010). Pre-planning of content, activities, timing and meeting/greeting and farewell were all important factors taken into consideration. Spradley's framework (1980) for observation provided a useful structure for data collection and synthesis and could be helpful in future planning and evaluation of arts for health initiatives. This programme is part of the emerging arts for health programmes in Manchester and across the North West of England (Health & Culture 2011; North West Arts for Health Network, 2013; Swindells et al., 2013), the overall national arts for health initiatives in the UK (Arts, Health and Wellbeing Research Network, 2012; Clift, 2012) and globally (Australia National Arts for Health Framework, 2012; National Center for Creative Aging, 2013).

Having sufficient staff to support the sessions is vital and it was noted that gallery/museum staff would need some training on aspects of working with older people, particularly memory problems, which concurs with others (Cameron et al., 2013; Rosenberg, 2009; Rosenberg et al., 2009). Museum and gallery arts for health in-reach and out-reach for community groups and older people are in keeping with the arts for health movement and civic access to museums, galleries and cultural heritage, who are increasingly required to justify expenditure and public benefit (Chatterjee, 2008; Chatterjee et al., 2009; O'Neill, 2010). Such programmes can also contribute to social and cultural capital, health inequalities, social justice and public health by promoting wellbeing and quality of life for the wider public and for those populations who tend to be socially excluded or isolated (Belfiore, 2002; O'Neill, 2010; Rosenberg, 2009). Camic and Chatterjee (2013) provide a culture and health framework that can be used by museums and galleries for public health and health promotion with local populations and the potential for a number of organisations to work together in partnership.

Creativity, wellbeing and older people

Comments and feedback from older people, staff and artists indicate there were immediate and short term benefits to people's wellbeing through social engagement, arts and cultural appreciation and creative activity. Older people were viewed as citizens in their own right with stories, life experiences and creative abilities that had been dormant. Participating in the programme provided opportunity to enrich people's lives, wellbeing and quality of life in keeping with findings of others (Cameron et al., 2013; Chatterjee et al., 2009; Roberts et al., 2011; Rosenberg et al., 2009; Swindells et al., 2013) and the basis for the arts for health initiatives locally, nationally and globally.

Strengths and limitations of the study

Strengths of the study were the use of pragmatic approaches to evaluate a 'real life' scenario based on inclusivity and rights of older people to engage in cultural activities, not focusing on diagnostic labels and not manipulating parameters. Data were qualitative and triangulated from observations, comments and field notes using a recognised framework and group discussion and was a feasibility study. Limitations include small sample size, only one programme, short time frame (6 months) and not having data for before and after comparison. Only few older people attended all or most of the sessions which on such a small sample would make before and after, between and within group comparison weak. An attempt was made to obtain quantitative data using the Outcomes Star for Older People (2013). Lead staff from each home were asked to undertake a before and after completion for each session with residents by the programme manager. Both staff reported they did not find the outcome stars useful as they could not always be completed by residents or proxy/carer and were focused on reablement measuring change in behaviour or wellbeing over time. The older people cared for had factors not amenable to change due to their being older, requiring care, limited activities of daily living or memory problems and as such measures were not found feasible. Other studies have used quantitative measures to evaluate arts for health programmes for people with and without dementia (Rosenberg, 2009; Rosenberg et al., 2009), with some requiring support to complete the measures; positive trends were identified for wellbeing but no significant differences were found. This may have been due to small sample sizes and complex measures but also reflect people's lives, circumstances and experiences are individual and before and after measures challenging. Brooker and Duce (2000) used the dementia care mapping (DCM) wellbeing six item scale in their day hospital controlled trial of reminiscence therapy. Use of this observation scale in future arts for health studies particularly with older people from care homes, with or without memory problems, is warranted and has not to date been specifically used in such initiatives.

Conclusion

The study has demonstrated that the arts for health programme is feasible and facilitates older people from care homes and supported living to access public museums and galleries to encourage creative arts, cultural appreciation and social engagement which promote wellbeing, quality of life and social inclusion. Further research is warranted to establish the ongoing benefits of such programmes using a range of qualitative and quantitative evidence and outcomes involving project teams comprised of researchers, arts for health

managers and curators, artists, care staff and older people as partners and participants. Such research could identify the benefits for older people not only during the visits but also between sessions in terms of their behaviour, mood, communication and social interaction when they return to the care home. Future research on the development of partnerships between museums, health and social care and planners to address social isolation in older people is warranted.

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Author contributions

BR was responsible for the conception, design, acquisition of data, data analysis, interpretation, drafting and revision of the manuscript. SM for data analysis, interpretation and critical comment on the content of the manuscript. WG, AW and TL for critical comment on the content of the manuscript.

Ethics approval

The study was reviewed and approved by the Faculty of Health & Social Care Ethics Committee, Edge Hill University – LTC 41.

Conflict of interest

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References

Abrams, R. C., Teresi, J. A., & Butin, D. N. (1992). Depression in nursing home residents. *Clinics in Geriatric Medicine*, *8*, 309–322.

Alzheimer's Society. (2012). *All party parliamentary group on dementia*. London: Alzheimer's Society.

Arts Council England. (2007a). *The arts, health and wellbeing*. London: Arts Council England.

Arts Council England and Department of Health. (2007b). *A prospectus for arts and health*. London: Arts Council England.

Arts, Health and Wellbeing Research Network. (2012). Retrived from www.artsandhealthresearch.ac.uk (accessed 20 April 2013).

Australia National Arts for Health Framework. (2012). Consultation. Retrieved from http://www.artshealthfoundation.org.au (accessed 20 April 2013).

Basting, A. (2009). *Forget memory: Creating better lives for people with dementia*. Baltimore: John Hopkins University Press.

Belfiore, E. (2002). Arts as a means towards alleviating social exclusion: Doe sit really work? A critique of instrumental cultural policies and social impact studies in the UK. *International Journal of Cultural Policy*, *8*, 91–106.

Belfiore, E., & Bennett, O. (2008). *The social impact of the arts. An intellectual history*. Basingstoke: Palgrave Macmillan.

Bohlmeijer, E., Roemer, M., Cuijpers, P., & Smit, F. (2007). The effects of reminiscence on psychological wellbeing in older adults: A meta-analysis. *Aging & Mental Health*, *11*, 291–300.

Brooker, D., & Duce, L. (2000). Wellbeing and activity in dementia: A comparison of group reminiscence therapy, structured goal-directed group activity and unstructured time. *Aging & Mental Health*, *4*, 354–358.

Brown, J., Bowling, A., & Flynn, T. (2004). Models of quality of life: A taxonomy, overview and systematic review of the literature. *European Forum on Population Ageing Research*. London: WHO.

Bungay, H., Clift, S., & Skingley, A. (2010). The Silver Song Club Project: A sense of well-being through participatory singing. *Journal of Applied Arts & Health*, *1*, 165–178.

Cameron, M., Crane, N., Ings, R., & Taylor, K. (2013). Promoting well-being through creativity: how arts and public health can learn from each other. *Perspectives in Public Health*, *133*, 52–59.

Camic, P., & Chatterjee, H. J. (2013). Museums and art galleries as partners for public health. *Perspectives in Public Health*, *133*, 66–71.

Chatterjee, H. J. (2008). *Touch in museums: Policy and practice in object handling*. Oxford: Berg.

Chatterjee, H. J., Vreeland, S., & Noble, G. (2009). Museopathy: Exploring the healing potential of handling museum objects. *Museum and Society*, *7*, 164–177.

Clift, S. (2012). Creative arts as a public health resource: Moving from practice-based research to evidence-based practice. *Perspectives in Public Health*, *132*, 120–127.

Darton, R., & Muncer, A. (2005). Alternative housing and care arrangements: The evidence. In B. Roe, & R. Beech (Eds.), *Intermediate and continuing care: Policy and practice* (pp. 183–203). Oxford: Blackwell.

Department of Health. (2009). *Living well with dementia. A national dementia strategy*. London: DH.

Froggett, L., Farrier, A., & Poursanidou, K. (2011). The who cares? Research: what can museums do for health and wellbeing: A study of the Renaissance North West Programme. Retrieved from http://www.gmcvo.org.uk/sites/gmcvo.org.uk/files/Who%20Cares%20Report%20FINAL.pdf (accessed 20 April 2013).

Froggett, L., & Little, R. (2008). *Precarious flight: An evaluation of the arts program running in UCLH*. Preston: Psychosocial Research Unit, UCLAN.

Gesler, W., Bell, M., Curtis, S., Hubbard, P., & Frances, S. (2004). Therapy by design: Evaluating the UK hospital building program. *Health & Place*, *10*, 117–128.

Hancock, G. A., Woods, B., Challis, D., & Orrell, M. The needs of older people with dementia in residential care. *International Journal of Geriatric Psychiatry*, *21*, 43–49.

Health & Culture. (2011). How museums and galleries can enhance health and wellbeing. Retrieved from HealthandCulture.org.uk.

Hoe, J., Hancock, G., Livingstone, G., Woods, B., Challis, D., & Orrell, M. (2009). Changes in the quality of life of people with dementia living in care homes. *Alzheimer Disease and Associated Disorders*, *23*, 285–290.

Knapp, M., Prince, M., Alabnese, E., Banerjee, S., Dhanasiri, S., Fernandez, J., . . . Stewart, R. (2007). Dementia UK: Full report. *A report into the prevalence and cost of dementia prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London, for the Alzheimer's Society* (p. 23). London: Alzheimer's Society.

MacPherson, S., Bird, M., Anderson, K., Davis, T., & Blair, A. (2009). An art gallery access programme for people with dementia. 'You do it for the mpoment'. *Aging & Mental Health*, *5*, 258–268.

Moos, I., & Bjorn, A. (2006). Use of life story in the institutional care of people with dementia. A review of intervention studies. *Ageing & Society*, *26*, 431–454.
Mozley, C., Sutcliffe, C., Bagley, H., Cordingley, L., Challis, D., Huxley, P., . . . Burns, A. (2004). Towards quality care. *Outcomes for older people in care homes. Personal Social Services Research Unit*. Ashgate: Aldershot.
NAO. (2007). *Improving services and support for people with dementia*. London: National Audit Office.
National Center for Creative Aging. (2013). Art and aging: Benefits. Retrieved from http://.creativeaging.org/index.php?id=43 (accessed 4 March 2013).
Netten, A., Darton, R., & Williams, J. (2005). Care homes and continuing care. In B. Roe, & R. Beech (Eds.), *Intermediate and continuing care: Policy and practice* (pp. 204–221). Oxford: Blackwell.
North West Arts and Health Network. (2013). Retrieved from http://www.artsforhealth.org/network/ (accessed 20 April 2013)
O'Neill, M. (2010). Cultural attendance and public mental health – from research to practice. *Journal of Public Mental Health*, *9*, 22–29.
O'Shea, E., & Leime, A. N. (2012). The impact of the Bealtaine arts programme on the quality of life, wellbeing and social interaction of older people in Ireland. *Ageing & Society*, *32*, 851–872.
Outcomes Star – Older People. (2013). Outcomes star – older person's star. Retrieved from http://www.outcomestar.org.uk/older-epeople (accessed 11 April 2013).
Phillips, J., Ajrouch, K., & Hillcoat-Nalletamby, S. (2010). *Key concepts in social gerontology*. London, England: Sage.
Phillipson, C. (2012). *Developing age-friendly cities: Policy challenges & options*. Housing Learning & Improvement Network. Viewpoint 37. Retrieved from www.housinglin.org.uk (accessed 12 November 2012).
Roberts, S., Camic, P. M., & Springham, N. (2011). New roles for art galleries: Art viewing as a community intervention for family carers of people with mental health problems. *Arts & Health*, *3*, 146–159.
Rosenberg, F. (2009). The MoMA Alzheimer's Project: Programming and resources for making art accessible to people with Alzheimer's disease and their caregivers. *Arts & Health*, *1*, 93–97.
Rosenberg, F., Parsa, A., Humble, L., & McGee, C. (2009). *Meet me: Making art accessible to people with dementia*. New York, NY: The Museum of Modern Art.
Roy, D. E., & Giddings, L. S. (2012). The experience of women (65-74 years) living with a long term condition in the shadow of ageing. *Journal of Advanced Nursing*, *68*, 181–190.
Royal Society for Public Health. (2012). *Arts and wellbeing: Recent developments, future challenges*. One day Conference, London, 9 February 2012.
Sampson, E. L., Thune-Boyle, I., Kukkastenvehmas, R., Jones, L., Tookman, A., King, M., . . . Blanchard, M. R. (2008). Palliative care in advanced dementia: A mixed methods approach for the development of a complex intervention. *BMC Palliative Care*, *7*, 8.
Scharf, T., & de Jong Gierveld, J. (2008). Loneliness in urban neighbourhoods: An Anglo-Dutch comparison. *European Journal of Ageing*, *5*, 103–115.
Spradley, J. P. (1980). *Nine dimensions of observation. Participant observation*. London: Wadsworth.
Staricoff, R. L. (2004). *Arts in health: a review of the medical literature*. London: Arts Council England.
Stern, C., & Konno, R. (2009). Physical leisure activities and their role in preventing dementia: A systematic review. *International Journal of Evidence-based Healthcare*, *7*, 270–282.
Stern, C., & Mumm, Z. (2010). Cognitive leisure activities and their role in preventing dementia: A systematic review. *International Journal of Evidence-based Healthcare*, *8*, 2–17.
Stickley, T. (2012). *Qualitative research in arts and mental health*. Ross on Wye: PCCS Books.
Swindells, R., Lawthorn, R., Rowley, K., Siddiquee, A., Kilroy, C., & Kagan, C. (2013). Eudaimonic well-being and community arts participation. *Perspectives in Public Health*, *133*, 60–65.

Ulrich, R. (1984). View through a window may influence recovery from surgery. *Science*, *224*, 420–421.
Valuing Older People. (2009). Manchester: A great place to grow older 2010-2020. *Public Health Manchester*. Manchester: Manchester City Council.
Victor, C. R., Scambler, S. J., Bowling, A., & Bond, J. (2005). The prevalence of, and risk factors for, loneliness in later life: A survey of older people in Great Britain. *Ageing and Society*, *25*, 357–375.
Vink, A. C., Bruinsma, M. S., & Scholten, R. J. P. M.(2011). *Music therapy for people with dementia. Cochrane Database and Systematic Reviews*. Chichester: John Wiley & Sons Ltd.
White, M. (2009). Arts development in community health. *A social tonic*. Oxford: Radcliffe.
World Health Organisation (WHO). (2002). *Active ageing: A policy framework*. Canada: WHO.
WHO. (2005). Preventing chronic diseases: A vital investment. Geneva: WHO. Retrieved from http://who.int/chp/chronic_disease_report/index.html (accessed 9 November 2011).
WHO. (2012a). 'Ageing' health topics. WHO. Retrieved from http://www.who.int/topics/ageing/en/ (accessed 18 December 2012)
WHO. (2012b). 'Life does not end at 60 – senior citizens have much to offer' healthy ageing. WHO. Retrieved from http://www.euro.who.int/en/what-we-do/health-topics/Life-stages/healthy-ageing/news/news/2012/01/life-does-not-end-at-60-senior-citizens-have-much-to-offer (accessed 18 December 2012).
Woods, B., Spector, A. E., Jones, C. A., Orrell, M., & Davies, S. P. (2009). Reminiscence therapy for dementia. *Cochrane Database and Systematic Reviews*. Chichester: John Wiley & Sons Ltd.
Woods, B., Aguiire, E., Spector, A. E., & Orrell, M. (2012). Cognitive stimulation to improve cognitive functioning in people with dementia. *Cochrane Database and Systematic Reviews*. Chichester: John Wiley & Sons Ltd.

Brenda Roe is Professor of Health Research, EPRC Edge Hill University and Honorary Fellow, PSSRU, University of Manchester. Her research interests include health and social care, organisation and service delivery and people's experiences of living with chronic conditions in a variety of institutional, community and care home settings. Recent projects have included incontinence, falls, dementia, quality of life, end of life and partnerships with older people.

Sheila McCormick's research interests include documentary, political and applied theatre. As a qualifying nurse and trained actor, Sheila obtained her MPhil in Irish Theatre and Film from Trinity College Dublin before being awarded a PhD in 2011 by the National University of Ireland, Galway for her doctoral thesis exploring British and Irish documentary theatre.

Terri Lucas worked as a visitor services assistant at the Whitworth Art Gallery during the *Coffee, Cake & Culture* project. She provided gallery tours for the groups and facilitated the workshop on story telling.

Wendy Gallagher manages *Health and Culture* programmes and partnerships at the Whitworth Art Gallery and Manchester Museum, and Central Manchester University Hospitals NHS Foundation Trust. The work has been recognised with two awards from the Royal Society of Public Health for innovative and outstanding contributions to arts and health research and practice.

Andrea Winn is curator of community exhibitions both out-reach and in-reach at Manchester Museum, University of Manchester. These exhibitions provide opportunities for local people to connect with objects from the museum's collection in their community.

Sophie Elkin is project worker for Irwell Valley Housing Association providing specialist services, accommodation, support and care for older people with memory loss to enable them to live independent lives as long as possible.