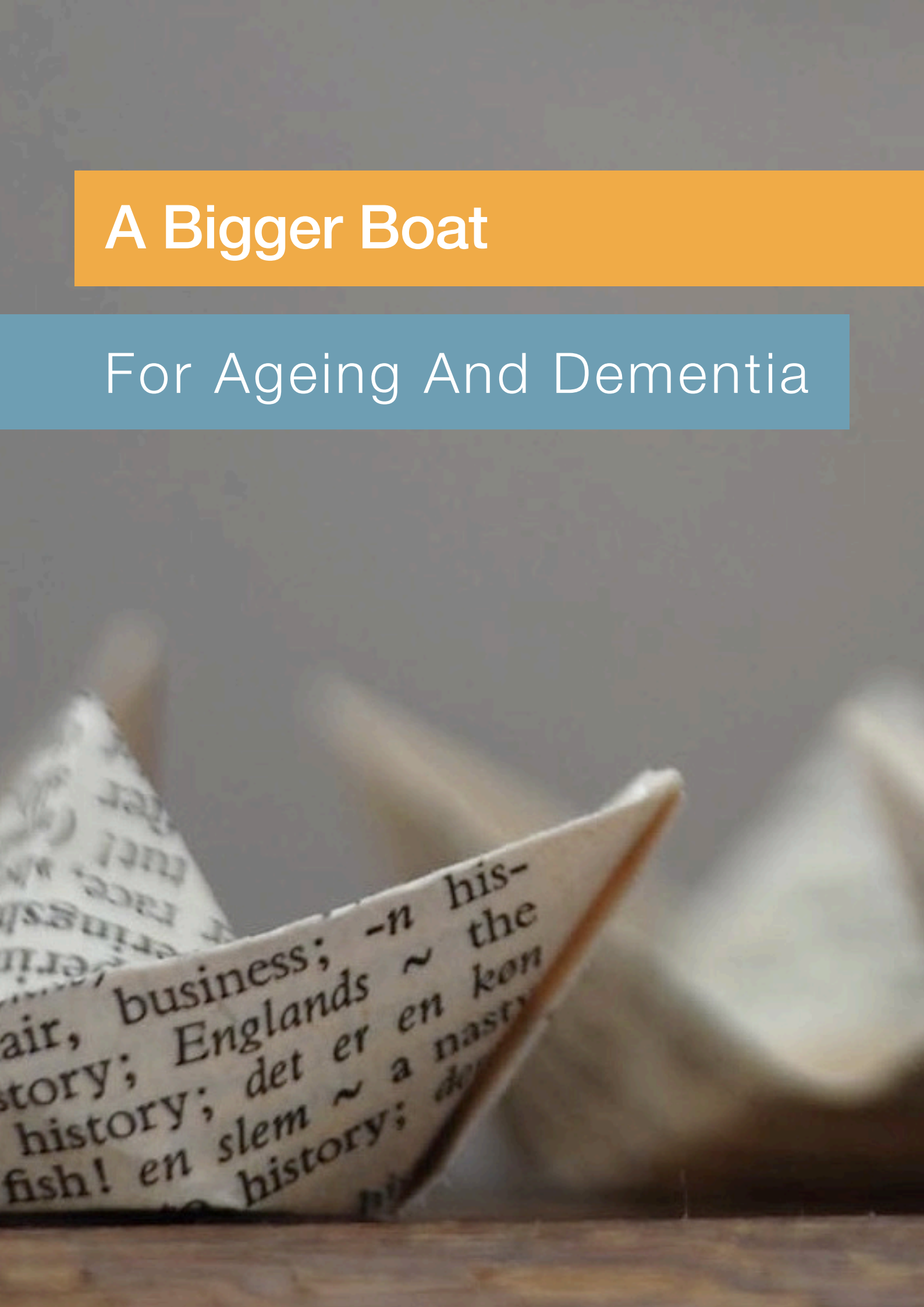
# A Bigger Boat

## For Ageing And Dementia



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# Contents

To prepare this report, our team interviewed over 50 pioneers across the field of Ageing and Dementia care to discover the world through their eyes. The insights here reflect their understanding of the challenges they face, as well as the vision they hold for what is possible.

Our approach is to listen deeply, and turn the wisdom of those who are closest to a problem into new and never-considered ways to take collective action. This is not a report. It is a call to action from those leading the way in the sector who are ready to step into their true potential.

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# Executive Summary

The challenges arising from ageing and dementia comprise one of the big, intractable problems of our era.  No single person or organisation can tackle these problems alone. And yet, for every complex problem there are innovators working to solve it from different angles, institutions, communities and sectors, each working more or less separately with insight into a particular piece of the puzzle.

To solve these complex problems at the scale necessary, we need to break down silos and bring these innovators together to share learning, surface insights and collaborate to achieve big goals. But this approach isn't easy: it requires trust, takes time and resource. And there aren't enough places in today's world where such **collaboration can happen.**

Our team interviewed over **50 pioneers** across the field of Ageing and Dementia care to discover: the world through their eyes; their understanding of the challenges they face; as well as the vision they hold for what is possible.

Our approach is to **listen deeply** and turn the wisdom of those who are closest to the ground into new ways to take collective action. Interviews revealed **hundreds of independent insights**, which were then clustered into related themes to reveal the patterns, anomalies, strengths and gaps in the sector.

We started with the question: "How can we ensure that older adults feel at home and connected wherever they are, and have a sense of wellbeing and purpose?" By focussing on this question in interviews we were able to identify the **overarching problems (Barriers)** the sector faces and the **underlying strategies (Design Principles) used to solve them**.

## Barriers

Five Barriers were identified through the synthesis of interview findings, which are briefly summarised here:

### Older People Are Not Valued

Ageing is inherently intertwined with a reality most of us avoid.  That reality is our mortality.

And so, by association, the fields related to ageing suffer from a withdrawal of individuals' and organisational engagement, as the actors seek, albeit subconsciously, to avoid confronting the reality of their own death.

### Citizenship Denied Through The System Of Care And The Caring Relationship

Time and again interviewees described a system where care is "done to" rather than with people and where systems were unable to acknowledge the potential or actual contribution of service users.

### No Mechanisms For Learning Or Knowledge Transfer

Interviewees uniformly agreed that transfer of knowledge relating to older adult and dementia care practice is lacking between professionals, between the general public (i.e. from one family carer to another), and from professionals to public and vice versa.

### Scale Is Seen As Implicitly Good

A combination of increasing acknowledgement of the impending economic impact of an ageing population, alongside a historical and political approach to public services that implies bigger and private as better, has created a situation where large-scale service provision is preferred and encouraged by commissioning bodies and institutions with the power to refer.

### Provision Lurches From Crisis To Crisis, Not Focusing On What Is Important

Structurally maintained by political, financial and management short-termism, a culture of continued crisis management is crippling the entire sector.

## Design Principles

Six Design Principles were identified, again briefly summarised:

### Enable The Individual

"People matter" was a mantra heard again and again across the interviews: empathy and compassion transform the care experience.

### Foster Meaningful Relationships

Interviews clearly identified the quality of relationships (professional, familiar and mixed), as critical to care outcomes.

## Move Through Care Pathways Incrementally

Graduated responses to an individual's needs deliver high quality, appropriate care. Incremental and integrated care pathways are healthy for all parties involved and potentially realise significant cost savings over current generally reactive approaches to care.

## Primacy Of Informal Over Formal

A plethora of examples of were provided that demonstrated the design principle that where informal care is given primacy over formal care the quality of the care, and how people feel about receiving their care is often better and costs are reduced.

## Keep Things At A Human Scale: Small Is Beautiful

Services designed so as to be delivered at a human scale, which inevitably means at a micro scale, consistently deliver such exceptional results that they are head and shoulders above other approaches to service design

## Local Matters

Keeping things local, so that relationships, knowledge and ownership of services are relevant to, and connected with, individuals delivers embedded and meaningful services.

# Discovery Map

The Discovery Map illustrates a framework in which we explore how organisations engage at the intersection of Barriers and Design Principles. It represents a call to action via a series of observations as to where new energies and resources could be directed, to support, bridge gaps, and radically magnify the impact of the existing, incredible work being done by current actors in the ageing and dementia care world. We used the Discovery Map as a starting point for discussion about the kinds of interventions and developments the sector needs, and to generate a number of explicit examples of opportunity areas and ideas.

Used well, the Discovery Map can act as a catalyst for the collective action towards cultural transformation it is ubiquitously agreed the sector so desperately needs.

# Introduction

## How Our Process Works

The effectiveness of our approach is derived from the combined 20 years of experience in complex systems analysis of the team that designed it. Its attributes include:

### It is inherently optimistic.

Our analysis begins by identifying what is working and succeeding in a given space, and then we look for ways to build on that success.

### It relies on the wisdom of those on the ground.

There commonly exists a significant gap between the theories of academics or consultants, and what is practiced as a solution on the front lines of the fight to solve any environmental or social challenge. Within that gap are insights and adaptations - flashes of brilliance - that often do not get captured by high-level views of the system.

### It distills patterns not otherwise visible.

The insights and adaptations drawn from the field, when knit together, provide new possibilities: for actors working on entirely separate aspects of a multidimensional challenge to potentially collaborate; to focus on segments of the problem that have been inadvertently ignored; and to understand how current successful insights could be more widely applied.

### It reframes challenges to allow for new thinking and new participants.

The definition of a problem shapes not only the types of approaches applied, but also the expertise invited to the conversation. Ultimately, multiple framings are necessary and compelling. For example, the quality of older person care is an issue grounded in human interaction. But it is also an investment issue and a policy issue. Without investors and policy makers in the room, alongside professionals from the field, important voices are left out of the solution set.

This report narrates the first phase of our work. In its entirety, the Bigger Boat approach encompasses later phases of convening, field research and strategic design. The analysis here sets the stage for these next steps and provides those interested with multiple options. Our analysis is qualitative in nature, not quantitative. It is meant to generate a framework for understanding a set of viable assumptions to shape the path forward, rather than a statistically derived proof.

## Project Scope

The Big Lottery Fund funded Bigger Boat to analyse the current state of ageing and dementia care in the UK so that it may identify transformative interventions to radically improve activities in the field.

The objectives of this first-stage analysis were to:

- Survey key innovators and practitioners at the cutting edge of care practice in the UK in order to distill a framework for understanding the full breadth of problems encountered and the underlying attributes that distinguish successful solutions; and
- Identify opportunity areas that outline possible next steps to transformation.

To these ends, our work included the following activities:

- Evaluating the inputs of individuals and enterprises interviewed and making observations around problems affecting successful activities and the solution-oriented approaches to those problems, in this way identifying key themes affecting the sector; and
- Analysing objective project attributes and drawing out the different operating methodologies that contribute to their respective successes.

## The Discovery Map: Understanding Crowd Wisdom

The Discovery Map is an integrative approach to understanding the multi-faceted nature of a problem and how its different components (Barriers) might be overcome. By segmenting the problem into Barriers, we acknowledge the complexity of the challenge and the need for strategies on several levels (Design Principles) to engage with those problems.

The Discovery Map highlights how these varied solutions work in concert across the dimensions of a problem to bring about real and lasting positive change - much like success in extinguishing a forest fire requires complementary, but diverse, tactics on multiple fronts.

We began by reviewing a variety of documents and reports that provided historical and contemporary context. We then interviewed 50 field leaders and experts. We scoured the reports and interview notes for explicit and implicit problems and successful solutions. Our criteria for a successful solution was that it needed to entail progress toward its intended goal, and that it needed to contribute toward the ultimate goal of large-scale and widespread positive transformation in the field of ageing and dementia care in the UK. The insights presented are based on the apparent success of solutions included in our analysis, rather than on statistical significance or impact metrics.

We sifted through the problems and solutions, clustering them into related themes. We then looked for patterns that pointed to overarching problems (Barriers) and the underlying strategies (Design Principles) used to solve them. These Barriers and Design Principles frame the Discovery Map.

The opportunities we present in this report identify some specific paths for consideration by actors looking to continue their efforts to build a flourishing ageing and dementia care sector.

Following is a summary of our findings, derived from asking our focussing question to interviewees:

*How can we ensure that older adults feel at home and connected wherever they are, and have a sense of wellbeing and purpose?*

Interviews started by asking this question and exploring problems experienced by the interviewee in relation to this through the explicit work that they were doing, along with the solutions they uncovered as a result of tackling these problems.  From this we identified the interviewee's positive and negative insights into the sector that were later aggregated (across all interviews) into Barriers and Design Principles

# Barriers

Barriers are the core challenges of a problem, which if successfully resolved could pave the way for real progress. They are not immutable conditions or context; they must be moveable and changeable within a defined time horizon.

## 01.

### Older People Are Not Valued

Ageing is inherently intertwined with a reality few of us engage with as often as perhaps we should. That reality is our mortality. Philosophers and psychologists posit a myriad of reasons as to why this is the case, but with a common theme being the intrinsic instinct to avoid death. And so, by association, the fields related to ageing suffer from a withdrawal of individuals' and organisational engagement, as the actors seek, albeit subconsciously, to avoid confronting the reality of their own death. Carers of elders are therefore also diminished in society's eyes, and subsequently both carer and elder sit in a system that rarely allows for opportunities of caring interactions that build respect, empathy and self-esteem.

In our reduction of older people's worth we have split[1] our elderly off from the rest of society and our collective emotional experience. In general society people "don't see beyond the grey hair". Older people garner no respect and the celebrity of youth in our current media is a form of implicit prejudice. In service provision the workforce concentrates on meeting physical health over holistic and/or mental health needs. Cleanliness (getting people out of bed, washed and dressed) is prioritised over meaningful activities and social engagement. People can be impeccably groomed yet terminally bored. What is the point of getting someone ready for the day if the day contains nothing worth getting ready for? This focus on task over quality of interaction or indeed quality of life, results in mechanised, factory care that dehumanises all parties in the system.

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1. Splitting, as defined by Wikipedia, is the failure in a person's thinking to bring together both positive and negative qualities of the self and others into a cohesive, realistic whole. See http://en.wikipedia.org/wiki/Splitting_(psychology) for a detailed explanation.

If carers and caring institutions were to really embrace the complexity that is at the core of the challenge of ageing it would mean they would be required to engage with and understand the whole person and so, necessarily, engage with the reality of mortality. To defend against this the challenge of providing good quality, holistic care is overlooked, the work propagandised as simplistic that anyone can do and left to underpaid and under-skilled staff. This further devalues the act of caring and the relationships underpinning it.

Blame culture is another manifestation of this societal splitting of older people. As a defence against death anxiety we all seek to avoid, people would rather blame others than take responsibility themselves. Poor practice is exposed as the work of people that are inherently immoral without exploration of the context and systems, which generated the behaviours in the first place. In response the caring profession naturally translates complaints as an attack. The resulting dynamic is of regulation, health and safety and risk aversion deployed as protection from these external attacks. The more fearful a manager is of external finger-pointing the more likely the people under his or her watch will "all be safely locked up inside", living according to strict routines that dare not allow for creativity or imagination – as this may lead to "accidents". So practice gets pushed further away from supporting holistic health and towards the task-oriented, factory-style care that dehumanises all parties.

Within the realm of evaluation this demeaning of elders and denial of a complex reality manifests in a number of ways:

- A focus on systems and monitoring crowds out the potential for meaningful care;
- As quality of life is hard to measure institutions and systems focus on quantitative measures that reinforce simplistic service provision and the undervaluing and distancing of older people from the very systems intended to aid them;
- Work done or support given by family carers is also often devalued and discounted.

The lack of value of carers for the elderly is seen in the paucity of quality training as well as a lack of funding for training throughout the sector, further impairing the carers in providing meaningful, high quality care. There are no on-ramps to careers in caring and no developed career pathways or workforce planning in the field.  Leadership development is close to non-existent (although often of excellent standards where it is present).

There is one last damaging cycle at play. The fundamentally negative perception of ageing that fuels the devaluing of care for older people, and therefore the poor standards of

care practice, compounds society's aversion to growing old. The more stories of abuse, loneliness and vulnerability we learn about, the less we want to confront our own fears and responsibilities. This creates a vicious feedback loop that reinforces both emotional and structural mechanisms that prevent us engaging meaningfully in the act of care and in doing so renegotiate our relationship with mortality.

In the end we all suffer, and in particular our elders who, while still very much alive and kicking, represent the thing most of us are unable to bear ourselves.

# 02.

## Citizenship Denied Through The System Of Care And The Caring Relationship

Time and again interviewees described a system where care is "done to" rather than with people and where systems were unable to acknowledge the potential or actual contribution of service users. This overwhelming and system-wide description flies in the face of the current vogue for personalisation and consumer choice, which by all accounts seems to actually disempower and reduce the ability for older people to make choices. A need for quality information over diversity of provision alongside a rarity of channels (for instance GPs who can vet and recommend services) deny individuals the ability to navigate personalised budgets and get access to the quality and diversity of support professed by the personalisation system to be of benefit to them.

The default positions across the sector are those of care "giver" and care "recipient" which, from interviewees' testimonials sets up a perverse power dynamic. Being a recipient of care especially when it is not for what is needed, or not provided with humanity and dignity, often belittles the recipient and leaves them with reduced agency and resilience. Indeed one interviewee stated that "sadly being dependent on care instantly diminishes you in the eyes of others." Dependency increases and the complexity and care requirements are compounded with associated costs spiralling upwards. Older peoples' opportunities to be active citizens in both society and their own care are curtailed while the current system denies them the possibility of being an active contributor to their own, and other peoples', care.

If one were to be cynical, telling an individual they have choice and control when in fact you know that the choices are few and far between, of questionable quality and difficult to access (and further to that when the individual has stated it is quality not choice that is important to them) then this could be seen to be an intentional manipulation. Indeed, some of our interviewees were just that cynical, one stating that the personalisation agenda was "an abdication of responsibility by the state."

The less negative view was that the personalisation care support managers and other community professionals such as GPs are simply working to inform and consult older adults requiring support. Yet the evidence shows that quality of life comes with agency and real choice – which only care relationships based on partnership, delegated power and of course citizen control can facilitate.

A major contributing factor to the denial of citizenship is in our use of language, framing and communicative transactions in caring relationships. How we communicate about reality (framing) is important because the words chosen imply values. In the same way that a pot of money could be framed as "public investment" or "taxpayer's money" so can a person be "supported" or "safe guarded". Older adult care is rife with language that reeks of control and institutionalism: "manual handling"; "feeding"; and so on – all of which reinforce the carer's position as someone that "does to" (i.e. guards and handles and feeds) and not with. In essence, the linguistic representation of equality is often missing in caring relationships.

# 03.

## No Mechanisms For Learning Or Knowledge Transfer

Low levels and poor quality of training prevent meaningful knowledge transfer from occurring across much of the sector. This is fuelled by a number of factors including, but not limited to:

- An ingrained culture, in part outlined above, that prevents a suitable level of resources to be deployed to learning and knowledge transfer;
- A competitive environment that silos working and disincentivises collaboration between different, often competing, actors in the sector;
- Short-termism, at political and managerial levels, that prioritises immediate outputs over long-term continuous improvement and so prevents investment in improvement.

Reinforced by factors such as there being currently no national minimum standards in dementia care training and little or no potential for career development in the field, staff have no incentive to engage beyond day to day tasks and towards learning and knowledge transfer for improved working. The onus to regulate the quality of continuing professional development (CPD) is on the employer and so with resource pressures as they are, and the field being viewed externally in with such low esteem, training and CPD becomes simply yet another tick-box exercise.

Interviewees uniformly agreed that transfer of knowledge relating to older adult and dementia care practice is lacking between professionals, between the general public (i.e. from one family carer to another), and from professionals to public and vice versa. Interestingly though it is also agreed that in the professional world there does exist a lot, and possibly even enough, knowledge when it comes to best practice. But knowledge is either getting lost in translation or is held on to and made prohibitively difficult for other actors to gain.

For professionals knowledge exchange platforms do exist; The Social Care Institute for Excellence (SCIE), The National Institute for Health and Care Excellence (NICE), The Kings Fund, The Royal College of Nurses (RCN) to name but a few. But as interviewees expressed time and again reading about something and attending classroom or workplace based training on something is very different from putting that new knowledge into practice. For family carers there are now many blogs by other carers and indeed by people living with dementia, which seek to enlighten, signpost, and support. But again when it comes to needing help with specific care experiences in the moment, websites can be of little use. Yet when it comes to helping individuals - professionals or otherwise - to transfer knowledge into practice, very little exists. What does exist is of an extremely high standard but the vast majority of this sits behind branding, copyright and fees beyond an average care provider's means.

The Care Quality Commission (CQC) would be in a strong position to signpost to training, knowledge, practice development tools and expert advice but they are unable to do so on the grounds of it being seen as endorsement and counter to their role as quality assessor. Until recently the observation tools inspectors themselves use (for example the Short Observational Framework for Inspection) are closely guarded so that staff have no way of preparing themselves to improve or see the raw observational data following inspection - only the findings report.

In addition many of the institutions contributing to the field are structurally prevented from sharing knowledge:

- Universities, who often hold much of the latest knowledge due to research, are increasingly operating as businesses and so collaboration of academics within and between universities can be problematic;

- The few relevant conferences that exist often preach to the converted as delegate fees are high and service providers tend to send their most senior staff not the frontline workforce, if they can attend at all;

- Service providers are in such competition that the little they are willing to share with others when it comes to practice development often comes by way of success stories that read as advertisements rather than accurate, vulnerable accounts of the slow-burn work, the real challenges faced along the way and

how, if at all, they were overcome.

Another gap in knowledge and awareness is at the “customer” end in what products and services are available to someone living with dementia, especially locally. There is almost a complete lack of route to market for organisations offering “Business to Customer” (B2C) services when it comes to dementia care. Practitioners and entrepreneurs reinvent the wheel while the public and professionals such as GPs and social workers resort to searching Google to try and find what might exist in the first place, right on their doorstep.

All of the above, combined with the poor ability to evidence quality of impact of service provision on an individual’s well being, leads to a disconnected, inconsistent and indiscernible quantity and quality of services addressing ageing and dementia across the country.

# 04.

## Scale Is Seen As Implicitly Good

A combination of increasing acknowledgement of the impending economic impact of an ageing population, alongside a historical and political approach to public services that implies bigger and private as better, has created a situation where large-scale service provision is preferred and the norm.

The reality is that this impedes good care in a number of ways, including:

- Commercial profit motives driving bad practice;
- Care home development at worst led, or a best influenced, by land and property development imperatives;
- Services becoming tiered and cross-subsidised as a result of different private and public funding streams;
- Larger size usually leading to larger hierarchies, within which actors are less able to think and behave creatively and autonomously.

The world of innovation in ageing and dementia also assumes that scaling is good despite the evidence suggesting otherwise with smaller, local and community organisations, individuals even, leading innovations in service provision across the sector. By implicitly assuming that the best way to infuse the sector with innovation is through scaling the preconditions that have allowed smaller innovations to flourish, namely gift economies, proximity, informal caring relationships that including reciprocity, etc, are denied.

This state of affairs is reinforced by a systemic bias against small organisations delivering services:

- Commissioning systems are biased against smaller providers;
- Practicalities and costs related to establishing and undertaking evaluation acceptable to institutional purchasers of services are prohibitive;
- High capital costs act as a barrier to small organisations entering the field;
- Funding applications are so vast, filled with grant-writing jargon and hidden methodologies, that smaller organisations have neither the time nor expertise to successfully compete for funds.

In this way the UK-wide focus on scale as the primary way to deliver services prohibits an environment that fosters the intimacy needed to deliver quality services.

# 05.

## Provision Lurches From Crisis To Crisis, Not Focusing On What Is Important

Structurally maintained by political, financial and management short-termism, a culture of continued crisis management is crippling the entire sector. There is currently much rhetoric about the desire and possibility of combining health and social care budgets. The theory is that this would be a positive move that would see an increased level of coordination in budget allocation to allow resources to be targeted at prevention rather than crisis management. In reality this change may further compound the sense of the sector being in a permanent state of flux that was cited repeatedly throughout the interviews.

Generally speaking decisions made in crisis are decisions made at the wrong time. The denial of ageing as a reality we all need to grapple with means that at an individual and family level changes in care, in housing and in the systems and structures that surround older people are more often than not made after a crisis. This is commonly acknowledged as especially problematic for older people. A significant contributing factor to this is the lack of care pathways that incrementally increase (or decrease) care provision on continua including “low-touch” to “high-touch” and informal to formal.

Other factors that trigger crisis in the lives of older people include:

- When disruption in caring provision occurs, for instance when a carer gets ill or goes on holiday;

- Where the current fiscal environment causes a withdrawal of service provision generally decreasing eligibility for support, which consequently increases the percentage of crisis intervention.

The above factors are reinforced through a system that effectively excludes family and informal care from much of the statutory and regulated care provision.

In summary, less resource is being asked to do more in shorter time scales while excluding family and informal care networks.  As a result crisis is neither mitigated nor averted and is increasingly occurring at the points along care pathways where it costs the most and is most detrimental to the individual.

# Design Principles

Design Principles are the underlying ideas or observations beneath the surface of a solution. Principles are not tools or solutions themselves, but ways to understand the mechanism a solution is addressing. They reveal truths about a system and insights to address longstanding stuck points.

## 01.
## Enable The Individual

“People matter” was a mantra heard again and again across the interviews.  It is clear that empathy and compassion transform the care experience and that these factors are only realised when people are enabled to be themselves within their caring role.

A different but related theme drawn out from the interviews was that when people are treated as if they are assets and not liabilities they become exactly this. And further, they then begin to treat the people they are interacting with as assets. Many interviewees described using Asset Based Community Development (ABCD) as the primary way to mobilise communities to build and maintain quality care infrastructure. ABCD uses local assets, meaning local people and the institutions they inhabit, to build stronger and more sustainable communities.  ABCD is by no means exclusively an approach used in ageing care, in fact it is an approach used globally and across multiple sectors. And ABCD is by no means the only way this approach was described by interviewees. However its repeated referencing across the interviews warrants its mention here.

Another theme emerging strongly from the interviews was around the concept of Goal Attainment Scaling, where older people set their own personal outcome measures and where these are set within a standardised measurement system to allow for statistical analysis, and to a certain degree aggregation and comparison, of results. While not yet widely used or acknowledged and certainly suffering from guidance around how to implement, Goal Attainment Scaling was widely seen as a powerful way to enable older people to have more and healthier choices and to allow them to speak with their own voice.

Interviewees reported that where family and informal carers as well as where older people were directly and actively involved in the design and implementation of caring, higher quality and kinder and more productive care was found to exist. Expressed with a particular eloquence one interviewee observed “things work when people give a shit.”

Where individuals inhabit an environment where they are able to take agency, as formal carer, informal carer or beneficiary of care, the quality of that care is of a different, substantially higher order. If, as one interviewee stated, “we can see the person not the age, disease or role label, (i.e. carer) then we can design systems that really work.

# 02.
## Foster Meaningful Relationships

Interviews clearly identified the quality of the relationships as critical to care outcomes. This was as true for relationships between between carer and older people as it was between carers, between older people and between individuals and relevant institutions. While this observation could be dismissed as a “no brainer” it is worthy of exploring the findings from interviews as participants clearly considered the presence, or absence, of meaningful relationships as a critical and deciding factor in the quality of care provision.

Whole family care coordination was cited as a way to maximise family involvement and therefore minimise formal care and costs of formal care as well as a way to support appropriate health and care prioritisation through family “ownership” of the care pathway or process. Increasing the quality of family interaction in the care process increases the quality of life of family members and the older person and quality of care of the older person.

Other approaches that fostered meaningful relationships that were identified during this work include:

- Co-design, where users are encouraged and empowered to develop solutions for themselves and which requires the establishment of meaningful bonds between care providers and users, is a feature of some of the more progressive organisations engaged with through this project;
- Co-production of events in care homes, where users led or were deeply involved with the production of all manner of social events and informal activities;
- Learning support between professionals, specifically action learning sets, where peers bring real world issues for collective discussion and reflection which is then converted into action, and informal support networks;
- Peer support between older people.

Admiral Nurses were another common reference point when interviewees talked about relationships as being central to quality care.  Admiral Nurses are specialist dementia care nurses who work across family, care and health institutions to provide quality care and improved quality of life by improving communication and maintaining the relationships that surround the person living with dementia. Reportedly under resourced and lacking political champions within the health and care services they represent a relationship-centric approach that could feasibly be scaled across the UK. Two other, related, approaches that were mentioned due to their relationship-centric approach and similarity to Admiral Nurses are:

- The Family Nurse Partnership model, currently used in the midwifery field to join up statutory service provision for at risk mothers-to-be from the first trimester of pregnancy to the second year of the child's life.  Over 15 years of data show care outcomes greatly improved and costs significantly reduced due to this approach;

- The idea of "cradle to grave" care, which is effectively the application of the Family Nurse Partnership approach to older person care, where a single person is liaison for an older person across all statutory service provision as well as the daily and weekly activities that life necessitates

A common theme that emerged was of the importance that secure and stable attachment between carer and older person played in ensuring quality, timely and appropriate care is delivered.

# 03.

## Move Through Care Pathways Incrementally

Graduated responses to individual's needs deliver high quality, appropriate care. Incremental and integrated care pathways are healthy for all parties involved and potentially realise significant cost savings over current generally reactive approaches to care.

Early interventions such as moving house, housing adaptations or changing care provision ahead of crisis or actual need extend this idea of graduated responses to need into the realm of prevention rather than just responsive or reactive approaches.

Extra care support and extra care housing, where care is introduced and incrementally increased as needed, is a good example of graduated care. Shared Lives Housing is another example of this where young people with housing need, often in tertiary education, live alongside older people and provide in-home support alongside older people in exchange for reduced rents (see entrepreneur case studies for more details). Other examples mentioned included mixed age co-housing schemes (where co-located self

contained homes share certain facilities) and the Dutch banding approach, which rates individuals on a scale of need and as a result is able to design graduated care approaches.

One logical conclusion to this approach that some interviewees flagged up is that care homes increasingly become viewed as palliative care facilities as more care is provided in community and in earlier, lighter touch formal and informal facilities.

# 04.

## Primacy Of Informal Over Formal

A plethora of examples of how informal care delivered better results than formal care were provided from right across the 50 individuals and organisations interviewed as well as the desk research undertaken. All pointed to a design principle that where informal care is given primacy over formal care the quality of care is better and costs are reduced.

The attitude and approach to informal care provision also changes the way participants feel about the care they are receiving. Often it enables more of a two-way benefit system where both parties feel they get something out of it. Similarly, it increased the general sense of satisfaction or quality of life in that moment of care receiving usually because informal care allows for the creativity and risk-taking normal in everyday life. And so regulated care transforms into unregulated living, where people are simply people once more, without labels or roles.

A common theme in much of what was reported was the act of integration: of services into the local community; of the local community into care homes and of care beneficiaries into service design and management. Having children's nurseries co-located with residential care homes was a favourite example given, although it appears there are few actual nursery-care homes working in this way. Another example was care home gardens acting as local community gardens and in so doing becoming a local community interface for older people. Of note was the observation that a strong common bond, between community and the older people, was needed to ensure successful integration and the subsequent "informalisation" of services as a result. Such common bonds reported included religious and, in the case of remote rural communities, geographic. One interviewee reported that where they had handed over management of the day centre, though a committee structure, it had transformed patients into citizens.

Efforts to place informal care as pre-eminent had greater traction and impact when they originated from formal care providers. Most notably reported was the approach of social prescribing by GPs, where social and health activities (indeed anything that is not clinical or medical) are prescribed by GPs in community and in place of medical prescriptions.

# 05.
## Keep Things At A Human Scale: Small Is Beautiful

Tied to the Barrier "scale is seen as implicitly good", which is detailed above, it was clear that we could not leave the idea that small is beautiful when designing services to be represented in this report only in the negative. Services designed so as to be delivered at a human scale, which inevitably mean at a micro scale, consistently deliver such exceptional results that they are head and shoulders above other approaches to service design. "Size doesn't matter" is how one respondent described it. But as a design principle it is so much more than this. Managing to keep design and delivery of services at this micro level, typically at a geographic level of no more than 20-30 streets or in numbers of perhaps no more than 50 people (and certainly no more than 150) ensures the environment is right for the other Design Principles here listed to have fertile ground to flourish and where the Barriers we have identified are able to be realistically overcome. Dog walking groups; local reading groups; care homes embedded in the immediate local community; micro enterprises that foster local community trust by having ambitions not to scale but to stay small; all are powerful examples provided of how small is indeed beautiful.

A factor that might aid keeping things at human scale, as reported in our research gathering, is the fact that the Internet and increasingly networked social structures are increasingly moving the cost of replication of ideas towards zero. Countering this, as detailed in the above Barrier, are the overwhelming realities that politically, financially and managerially big is seen as better. To change this perception would be to unlock a wealth of talent and experience at the coalface of care across the UK.

# 06.
## Local Matters

Keeping things local, so that relationships, knowledge and ownership of services are relevant to, and connected with, individuals delivers exceptional, embedded and meaningful services. Locally available services, which are known about and accessed through local networks, are in general higher quality and more relevant to service users than those not anchored in the local community. By attending to matters locally, service providers ensure that older people matter.

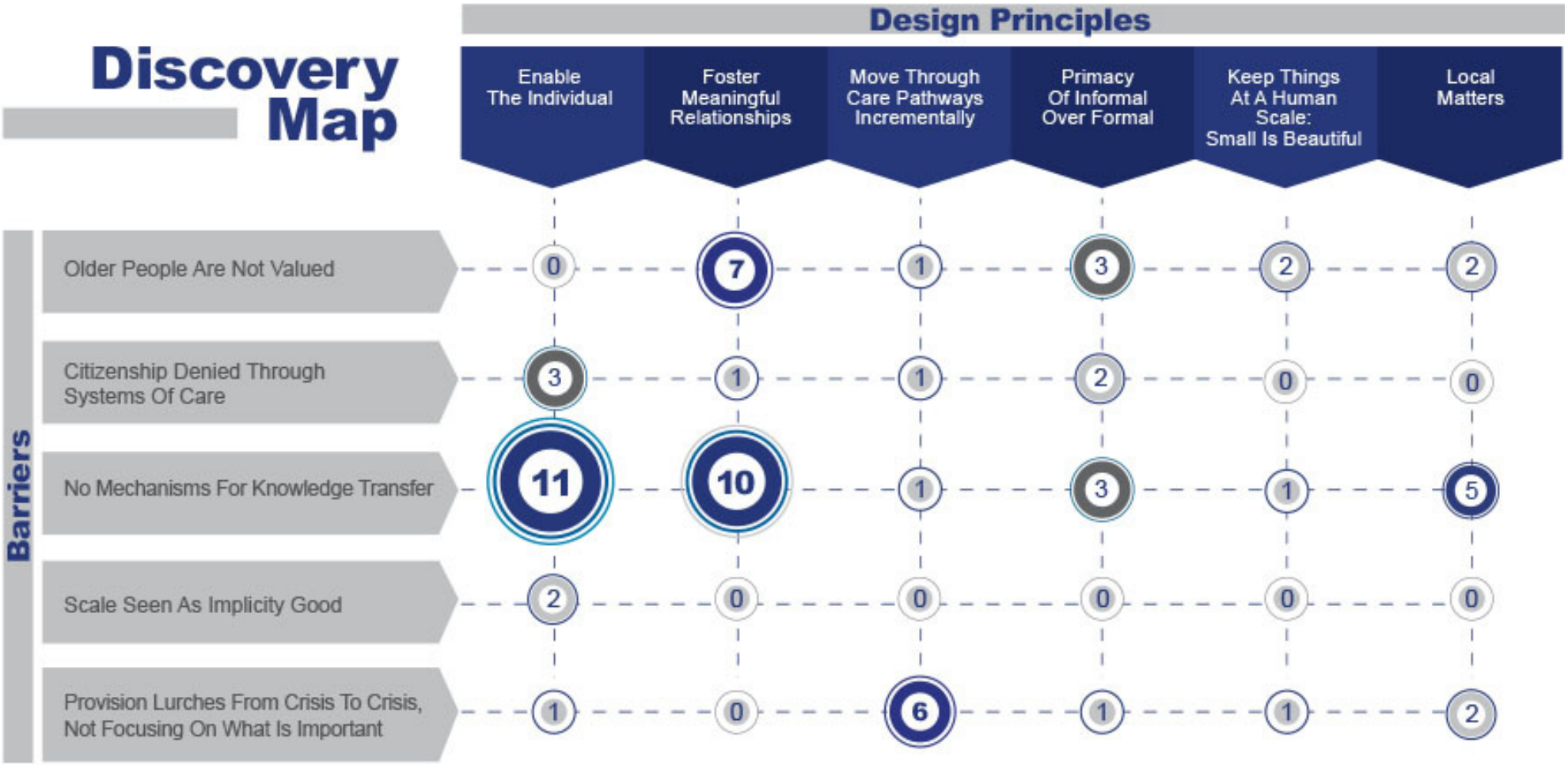
If ownership of a service (actual or emotional) is in the hands of the community from the outset there is a far greater level of community involvement than if this is not the case. Examples of this include:

- Local community centres that are used as meeting places for older people and people with disabilities and their families;
- Services which use local knowledge to map where, for instance, benches and publicly accessible toilets are so that frail older people are able to access this information ahead of planning a trip to the shops;
- Work to embed care home activities within local community activities.

# Discovery Map

Each interviewee's organisation/project was plotted as to where it foremost sat within the barriers and design principles.  If one organisation had two clearly defined projects, they were mapped separately. The numbers are the aggregates of where projects lie. For example, there are 11 projects that are working on enabling the individual by trying to provide knowledge transfer.

# Discovery Map



# Entrepreneur Profiles

## Design Principle One: Enable The Individual

### *Neil Maiden: Centre For Human Computer Interaction (HCI) Design, City University London*

The Centre for HCI Design generates research, teaching, consultancy and business services focussing on the relationship between people and innovative technology with the aim of creating more useful and usable systems. Recent EU funding led to the HCI Centre researching and developing mobile applications focussed on the relationship between creative problem solving and learning tailored to workers caring for older adults, including people living with dementia, in care homes.

The apps facilitated carers to provide person-centred care by enabling the individual carer to have more control over what information was learned, shared or imparted, when and where. The carers reported feeling more confident and autonomous in evidencing their good practice, finding solutions to complicated scenarios and creating plans of care that had the benefit of creative and holistic thinking through reflective practice, as prompted by the applications.

### *Andy Bradley: Frameworks4Change*

Frameworks4Change is a training and consultancy business with a focus on building trust, safety and co-operation primarily in the Health and Social Care sectors. The organisation places compassion at the heart of their work.

A programme may comprise support for leaders to reflect on compassionate leadership in high pressure environments; compassionate practitioner training for ward level leaders; seminars for front line staff; and an on-site audit tool. The aim is to build a culture of compassion to transform the way teams work together and leaders behave in service of a consistently caring and person centred response to people with dementia and their families. Frameworks4Change's work invites people to look after themselves more

consciously to enhance their wellbeing so that they can be more emotionally available to patients, customers, and colleagues. In this sense they enable the individual to live a good life, so that they can support others to do the same.

### *Dawn Brooker: Association of Dementia Studies, University of Worcester*

The Association for Dementia Studies (ADS) aims to make a substantial contribution to building evidence-based practical ways of working with people living with dementia and their families that enables them to live well. This is done primarily through research and education.

In particular the ADS helped create the free online toolkit called Care Fit For VIPs, that gives everything needed to get started on understanding and implementing person-centred dementia care. The toolkit is easy to use and enables any motivated individual within a service provider to lead their own practice development project and overcome all the usual barriers.

### *Julienne Meyer: My Home Life, City University London*

My Home Life (MHL) is a collaborative movement of people involved with care homes for older people. It seeks to improve the quality of life of everyone connected with care homes for older people and has now become the recognised voice for the sector which promotes best practice through transformative action.

As part of the leadership support and community development programme MHL facilitates Action Learning Sets[1] for care home managers. The managers get to explore issues they find challenging at work and through the process of the action learning set they find their own solutions. The learning that results improves each individual's problem-solving skills and communication skills. Managers report feeling more valued and enabled to work more effectively in their role.

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1. Action learning is an approach to solving real problems that involves taking action and reflecting upon the results. The learning that results helps improve the problem-solving process as well as the solutions the team develops. The action learning process includes (1) a real problem that is important, critical, and usually complex, (2) a diverse problem-solving team or "set", (3) a process that promotes curiosity, inquiry, and reflection, (4) a requirement that talk be converted into action and, ultimately, a solution, and (5) a commitment to learning [http://en.wikipedia.org/wiki/Action_learning].

## Design Principle Two: Foster Meaningful Relationships

### *Roger Jones: Older Men's Network*

The Older Men's Network is a network designed to give as much information and support to individuals and organisations that want to make a difference to older men's health and wellbeing. The network supports many groups across the country including Men In Sheds, Slimming without Women and Walking Football.

Men that participate in a group get together to have a good time, enjoy each other's company, support each other, increase their social network, decrease social isolation and build confidence. Furthermore, this positive relationship building occurs while working towards contributing to the community and/or improving one's physical health.

### *Helen Allen: Community Catalysts - Incubation of and Partnership with Shared Lives*

Shared Lives is a little known alternative to home care and care homes for disabled adults and older people. It is used by around 12,000 people in the UK and is available in nearly every region of the country. In Shared Lives, a Shared Lives carer and someone who needs support get to know each other and, if they both feel that they will be able to form a long-term bond, share family and community life. In Homeshare, someone who needs support to continue to live independently in their own home is matched with someone who lacks housing and they trade housing for low-level support. It often works inter-generationally with, for instance, a mature student or a public services worker on a modest income going to live with an older person who needs low-level support.

The relationships formed through shared lives approaches can be lifelong and participants often say "She/he is just one of the family."

### *Sarah Caplan: The Silver Line*

The Silver Line is the only free confidential helpline providing information, friendship and advice to older people. It is open 24 hours a day, every day of the year.

The more isolated people get the harder it is for them to reach out socially. Crises, such as bereavement, only compound this further. A phone call can be made without anyone watching or judging and the Silver Line staff are there to talk to any person at the time they reach out. Furthermore, the organisation offers weekly befriending calls with someone roughly matched to the older person's interests.

## Design Principle Three: Move Through Care Pathways Incrementally

### *Rachel Thompson: Admiral Nurses*

Admiral Nurses (run by Dementia UK) are specialist dementia nurses working in the community with people living dementia, their family members and collaboratively with other professionals. They use a range of interventions that help people live positively with the condition and develop skills to improve communication and maintain relationships. Admiral Nurses meet the need, as reported by older adults, of having one expert point of contact for an individual with dementia and their family throughout the dementia journey. They provide the tools and skills to best understand the condition as well as emotional and psychological support through periods of transition as well as the ability to refer and liaise with other healthcare professionals on behalf of the family. To this end they can alter the levels of support to meet the usually incrementally increasing needs of the individual and their family.

### *Cath Dillon: Circle, Participle (also Design Principle Four: Primacy Of Informal Over Formal)*

Circle is an innovative membership-based service open to anyone over the age of 50 supporting individuals and communities to lead the lives they want to lead. Members are supported across four areas of their lives: social activity; life's practical tasks; tailored learning; and appropriate health and wellbeing services. At the heart of Circle is a fundamental belief that everyone has the right to a flourishing, independent later life. Circle knows that life inevitably involves various points of crisis and stress. Circle does not believe in waiting for people to develop a problem, which then needs to be accentuated in order to have access to services and support. Rather, the role of Circles are to provide support into peoples' lives in a variety of ways so that crisis points can be avoided as much as possible. Then, if they do appear, Circle and its membership will be there to support each individual in a way that is truly personalised. In this respect Circle is transforming the provision of older people's services by being both preventative and reactive to support people as people not just as individuals within a system.

## Design Principle Four: Primacy Of Informal Over Formal

### *Start Arnott: Mindings*

Mindings is a private social network that shares content on a digital screen, akin to an interactive digital photo frame, in a person's home. It connects socially isolated people to their family, friends and community and in so doing provides reassurance that they're okay. Rather than sensors and devices that monitor and track an individual's wellbeing Mindings sits "near ambient" within a person's home and lets the individual engage with it on their own terms. Furthermore, the onus is on the sender to share a thought or experience with the older adult and as a thank you the sender gets a message to say the person has seen this and is therefore doing ok as opposed to the older adult giving up dignity and privacy to give others peace of mind. Mindings is also working to connect people with similar interests as well as local community members together all to support the wellbeing of more isolated older adults.

### *Clea House: Magic Me*

Magic Me is an arts charity that brings the generations together to build a stronger, safer community. Projects often link unlikely partners. For example young people aged 8+ and adults aged 60+ team up through shared, creative activity. Intergenerational groups meet on a weekly basis in schools, museums, older peoples clubs, care homes, community and cultural organisations.

In particular Magic Me's programme of Cocktails In Care Homes has gained national acclaim. It's popular because everyone feels like they get something out of it and as a result hundreds of volunteers have asked to be part of the programme in London. Volunteers comprise a majority of young, working adults who typically don't volunteer or have access to the care home system. But Cocktails In Care Homes makes volunteering fun and feasible, partly because it's after the working day, which is unusual.

### *Neil Mapes: Dementia Adventure*

Dementia Adventure connects people living with dementia with nature and a sense of adventure. They provide training, research and consultancy services all with nature in mind. They work in partnership with individuals and organisations across the UK so that all people living with dementia can have a sense of adventure in their lives regardless of where they live.

Dementia Adventure does not sit within the realm of care services. They are not regulated by the CQC yet the impact they have on health and wellbeing is not in doubt because they help people to enjoy living. Dementia Adventure is restorative in its positivity and thirst for the good life.

### *Simona Florio: Healthy Living Club*

Healthy Living Club is a self-directed, dementia-centred community meeting weekly in Stockwell, London. The group meets for four hours each week for a programme of activities developed to alleviate the symptoms of dementia and to promote the mental and physical wellbeing of those people with the illness. Each meeting is run as a social event, which people attend to meet each other, have a good time and share experiences. The Club is run with a team of volunteers and some sessional contributors and led by a paid co-ordinator. It is seen as a blueprint for future dementia care in the community. Local people with dementia and their carers have a social focus every week, often in place of isolation. The Club is self-governing and adapts to the changing needs of its members as their condition progresses. This is a shining example of people coming together as people, not as service-users.

## Design Principle Five: Small Is Beautiful

### *Helen Allen: Small Good Stuff, Community Catalysts*

Community Catalysts harness the talents of people and communities to provide imaginative solutions to complex social issues and care needs through very small-scale non-traditional models of care and support. They are passionate about bringing choice of high quality, small-scale local services to people wherever they live. Community Catalysts runs Small Good Stuff, a network which links people, organisations or groups who offer support, care or services to people in their local community on a very small scale with people who need care or support to live their life. Small Good Stuff offers very small organisations that offer support, care or services to people in their local community information, advice and resources.

## Design Principle Six: Local Matters

### *Ralph Broad: Inclusive Neighbourhoods*

Inclusive Neighbourhoods values the inherent strengths, capacities and contribution of all people in society. It works in partnership with individuals, families and local communities to support them to pursue and realise their vision for a good life and to create stronger, more welcoming communities. Inclusive Neighbourhoods also works with local authorities,

statutory services, local communities and provider organisations to reimagine the possibilities of how services can become more personal, flexible, accountable and efficient. Local Area Coordinators (LACs) start to get to know individuals and their families and build up a picture of the local community and its networks. Generally people are viewed as passive recipients of care and support packages, which don't often meet the stated needs or aspirations and do not build personal reliance. LACs turn the system on its head, intentionally helping the individual to build their own capacity with friends, family and neighbours using the local resources and using formal systems as the last port of call.

# Opportunities and Ideas

Our research focused on identifying and distilling the experiences of people on the ground and pioneering in the field of ageing and dementia care in the UK: Who are they? What defines their work? What obstacles have they encountered? How have they developed solutions?

From this discovery process, we synthesised our findings into five Barriers that constrain efficiency and effectiveness in the field, and six Design Principles that can successfully overcome those Barriers.

We explored solutions and made observations about where new energies and resources could be directed, under four broad themes:

- Unlocking the existing expert knowledge to the older adult care sector at large;
- Catalyse a culture change towards an appreciation of small and beautiful services;
- Truly value and enable older adults on a systemic level, independently and interdependently;
- Enable current systems to step up provision incrementally, as needed

Through conversations with experts in the field, and idea generation sessions from within our team, we looked for the biggest challenges and the changes that would yield the greatest impact. Together, we devised 29 ideas - some realistic, some shoot-for-the-stars - that could help to advance the field. We clustered them into areas, underneath the broad themes, to aid navigation of the breadth and depth of opportunities available as well to as assist with idea-comparison.

All of the specific ideas offered in each area are examples of how these opportunities might be pursued. All of them would require further research to customise and fully develop

There lies an interesting paradox: it is universally agreed that little or no knowledge is transferred across the sector, and yet the largest cluster of organisations sit in the matrix precisely in the space of knowledge transfer. These organisations are widely acclaimed as having excellent knowledge and skills, so we will assume quality is therefore not an issue.

If older adult and dementia care is viewed as a 'market', it is a vast and ever-growing one, so one aspect is simply that while there are a lot of high quality organisations offering knowledge, many more are still needed. But from our insights earlier there are other factors complicating the unlocking of knowledge being released to the sector:

- In professional spheres, the implementing knowledge into practice remains largely an unknown art and science;
- Egos and ownership get in the way of open access via branding and copyright;
- Individuals and organisations, including academia, are ingrained in competitive rather than collaborative ways of working;
- Conferences tend to show and tell rather than share and foster dialogue, and are prohibitively expensive for those who most would benefit from attending; and
- There is a complete lack of business to customer market of older adult and especially dementia care products and services.

The following ideas use the design principles previously outlined to over come these challenges and unlock the knowledge for all:

## Opportunity Area: Magnify The Impact Of Existing In-Sector Knowledge Transfer

While the knowledge exists in-sector to effect substantial disruptive, positive, change the mechanisms to transfer this knowledge across different actors in the sector are limited. Arguably, as we explain elsewhere in the report, some of the existing knowledge transfer mechanisms actually reinforce poor exchange of knowledge. What we need is systems innovation, sector wide!

# Idea 01.

## [Re-] Establish An Institute Of Innovation and Improvement

There used to exist an NHS Institute for Innovation and Improvement (now replaced by NHS Improving Quality, but without the same remit), well funded and consequently of good quality and revered in the sector. The Institute developed resources specifically around the science of implementation - one example was a 'productive ward' based on practice development methodology. Professionals could go through a programme of how to put particular knowledge and skills into practice, themed in mental health, acute care, and so on.

As described earlier, putting knowledge into practice, and especially developing entrenched cultures and practices within a long-standing institution, requires intensive support over months if not years. Often the expertise for this does not sit within an organisation, so an Institution that specialises in implementation and openly offers its experts to the sector (due to being properly funded) is crucial in moving the standards of care for older adults forward across the country. Each new story of culture change and practice development could be shared freely, with challenges as well as successes given equal priority.

The role for a National Institute for Innovation and Improvement is clear in that it would address many of the underlying barriers to quality knowledge transfer at scale across the UK.

# Idea 02.

## Lobby Large Funders To Make Capacity Building Finance Available Only If Results Are In The Public Realm

A key barrier that prevents organisations being able to learn from each other is the lack of evidence in the public realm that might be used to ascertain good and poor practice and so support improvement of existing practice and new replication of good practice. Much of the knowledge transfer / consultancy activity in the sector is conducted by commercial organisations whose interests it is in to protect service improvement so they may 're-sell' their services. If the large funders, who often directly or indirectly, fund this consultancy work specified that results had to be in the public realm then this barrier to exchange of knowledge around practice would, at least in part, be removed.

### Opportunity Area: Reduce The Cost, And Increase The Provision, Of Professional Services For Practice Development

As explained above much of the consultancy and knowledge transfer in the sector is undertaken by a small number of commercial players, often aligned to or originating from universities. A number of strategies could be adopted to reduce the cost and increase the range of provision of professional services for the sector including: increasing competition and attracting subsidy.

# Idea 03.

## Make The UK Market Case For Overseas Professional Services Organisations To Enter The UK Market

It would be realistic to encourage overseas professional services firms to establish practices in the UK simply by evidencing need. Similar approaches have been taken recently in social investment and in the early 2000's in waste management and recycling, amongst others. A market report and programme of communications to best-in-field practitioners on the continent and perhaps further afield would be a short piece of work with potentially long term positive outcomes.

# Idea 04.

## Access Knowledge Transfer Partnership (KTP) Finance To Embed Change Managers Into Care Homes And Other Care Providers

KTPs create a relationship between a company and an academic institution to facilitate the transfer of knowledge, technology and skills. Projects vary in length between six and thirty-six months and are funded through the Technology Strategy Board. There is ample potential for scholars in change management and/or health and social studies to work within a care provider to implement practice development and culture change initiatives with the aim of improving practice and quality of life for the people receiving care.

The scholar (KTP "associate") then gets to earn a decent wage, and benefit from both classroom and hands-on 'industrial' training, creating clear advantages to future employment opportunities in the sector. The academic organisation gets to develop real-word applicable teaching and research materials, and publish highly relevant research papers. As previously discussed, there is a paucity of knowledge and knowledge transfer

when it comes to practice development in care, and KTP opportunities would sit exactly within this niche. Finally, care providers self-create a competitive advantage through partnering with academia through open access to the latest research findings in health and social care, thus sitting at the forefront of innovative practice.

### Opportunity Area: Local Dementia Services Mapping

An individual newly diagnosed with dementia, or indeed a friend, family member or professional supporting them, should have free and easy access to the range of products and services available to them. It would be important to know (about these products and services): how close or far away they are; what they do exactly; how to contact them or find out more; how much they cost; and what other people who have used them think of them. This information would give the individual far more confidence that there are people around that have experience with dementia, and far more agency to make choices and live a full life. It would also enable organisations to see what is available, so that quality and/or geographical gaps in the market could be filled and the wheel is not re-invented.

# Idea 05.

## Competition To 'Get On The Map'

Borrowing from a number of business plan competition formats, a relatively small prize could act as an incentive for organisations to "get on a map of the sector". Some of the most successful examples of this can be found at www.changemakers.com where a simple, open source competition application form combined with a small prize fund has mapped thousands of players in multiple sectors, and identified key information used for detailed sector analysis.

# Idea 06.

## Piggyback Pinterest, Google Maps, or similar

Another way of approaching the challenge of mapping service provision is to piggyback on existing web based map systems and allow users to contribute both details as well as rank providers. A natural partner for this would be Engage & Create who are already working on a Dementia Directory.

## Opportunity Area: Leadership Support And Development For Leaders In Care

It is widely recognised that leadership skills, above and beyond managerial skills, are critical to ensuring a good quality care service. A leader can inspire others to step up and lead, and so a positive chain reaction can occur. Also recognised is how difficult the role of care home manager can be. They are sandwiched between an overworked, under-trained and underpaid staff, highly critical government authorities and the general public, while the landscapes of funding, policy, quality assurance and best practice guidelines shift continually beneath their feet. It takes a special kind of person to flourish in such an environment! A national leadership support and development programme would help even out the quality of the leadership in the sector, and provide the older adults receiving care services with a much higher chance of engaging with a carer who is valued, skilled, knowledgeable, compassionate and themselves continually supported and developed.

# Idea 07.

## Supercharge The My Home Life 'Leadership Support And Community Development' Programme

There already exists a tried and tested programme of leadership support for Care Home Managers. It has successfully helped over 200 care home managers improve relationship-centred care in their homes. Embedded in the programme are continual Action Learning Sets for the managers, and those that have gone through the programme report a wealth of positive outcomes and changes to their working life.

Government funding to ensure all care home managers across the country are enabled to take this course would greatly help achieve the National Dementia Strategy objectives 11, 12 and 13 so that all people living with dementia can receive high quality care services. Furthermore, supercharging the programme could include working with the Care Quality Commission so that a manager's participation in My Home Life (MHL) would be one way to evidence positive work in all Key Lines Of Enquiry (KLOEs) within the Inspection Domain 'well led' (and indeed many other KLOEs from Domains Safe, Effective, Caring and Responsive).

Finally, partnership with other-sector Action Learning Set leaders and participants could offer fresh ideas and perspectives to generalised leadership and workforce development challenges, reduce stigma through raising awareness about the sector, and entice external compassionate expertise to innovate and support the improvement of quality in care services and older adult quality of life.

## Opportunity Area: Showcase And Champion Innovative Use Of Space In Care Homes

Much good practice lies behind closed doors. It needs exposing to the world – showcasing so that professionals, service users and the general public alike – can see what is possible and experience the physical spaces of care homes as spaces that are as exciting as they are therapeutic. We need a coordinated campaign to showcase and champion the innovative use of space in carehomes.

# Idea 08.

## Develop National Partnership With Royal Institute of British Architecture (RIBA)

RIBA are already acting in the space of ageing through their recent report titled “Silver Linings: The Active Third Age and the City” where they illustrated six scenarios where engagement with ageing in urban environments could transform our built environments and therefore the lives of everyone who engages with them – not just older people. A logical next step would be to form a working partnership with RIBA to take these, and other illustrations, closer to real world implementation.

# Idea 09.

## Put A Care Home On The Roof Of The Royal Festival Hall

Be realistic - demand the impossible, so the old saying goes. A restaurant perched atop the Royal festival hall in 2012, so why not a care home? It’s ambitious and high profile and as such exactly the kind of head-turning headline needed to show exactly what is possible when care home spaces are used excellently!

# Idea 10.

## Create A Brokerage To Match Nursery Providers With Care Home Providers

Much talked about but rarely seen is the twinning of childcare facilities with care homes and day centres for older people.  So why not encourage more of this collaborative activity, that benefits the old and the young alike, by creating a brokerage to match childcare providers with care homes and day centres of older people?

# Idea 11.

## Case Studies And Conference Presentations

A simple intervention, building on the recent 'Community Engagement' report from My Home Life which provided a vairety of best practice case studies, would be to increase this bank of case studies and create a range of presentation materials for conferences and relevant public events to showcase innovative approaches to space management in care homes.

Opportunity Theme: Catalyse A Culture Change Towards An Appreciation Of Small, Beautiful Services

Small services are often emotionally and/or actually owned by locals, which we know improves engagement, quality and sustainability. They can be flexible and creative when often large organisations cannot be, and are much better suited to blending the informal with formal, as is wanted and needed. There is a plethora of outstanding innovation in micro enterprises that could be celebrated. To shift culture away from the mantra of 'growth', and towards 'lots of little', we need to tackle:

- Commissioning so that it respects and recognises smaller organisations as equally viable candidates for funding;
- Evidence gathering and fund-raising so that smaller organisations can afford to do it well; and
- Ways to support replication over scale, so that micro enterprises can learn from each other and create services that may draw on similar missions or visions, but be remain locally designed and emotionally owned.

### Opportunity Area: Supercharge Experience Led Commissioning

Experience Led Commissioning (ELC) provides a new way of approaching commissioning, service redesign and whole system change, which is evidence-based and driven by the ambition to deliver a fantastic care experience. It resonates perfectly with the NHS's ambition to deliver 'no decision about me without me' and fills a significant gap in 'know how' for CCGs. Would it be possible to supercharge ELC and in so doing positively disrupt the commissioning paradigm nationally?

# Idea 12.

## Set Experience Led Commissioning (ELC) Within The Context Of EU Procurement Legislation And Promote Lawful Pathways To Undertake ELC

Commissioning activity is set within the framework of EU and national procurement regulations, which in general frustrates alternative, devolved approaches to commissioning. However there are a number of proven “work arounds” and exceptions that may be applicable to ELC, and other alternative approaches to commissioning in older person care. Identification of all options and then an assessment of fit to sector commissioning activity (including ELC) could provide a powerful resource to practitioners struggling with commissioning by statutory bodies.

# Idea 13.

## Create Network Of ELC Early Adopters

There is a growing number of Clinical Commissioning Groups that are benefitting from being able to listen to the real wants and needs of their local communities, and funding services accordingly. A network of these ELC early adopters would serve to gather and strengthen the evidence-base, continually develop the methodology, and key members can act as champions to further promote and embed the experience-led approach across the country.

### Opportunity Area: Change National Policy And Perceptions To Prefer Human Scale Services

It would be a tall order to change national policy and perceptions to prefer human scale services. What would this look like? How would we start? Such a plethora of ideas could be generated in this area. We have chosen just two to highlight just a few as potential starting points to addressing such a huge issue.

# Idea 14.

## Work Through Share Action To Increase Pension Fund Investment Into Care Homes

Share Action is the UK charity that promotes responsible investment by pension funds and fund managers.

Engaging with Share Action sector actors could work to move investment in the larger care homes from funds with high investment, short timeline expectations to funds with more reasonable expectations of returns over longer time horizons, for instance the pension fund industry. In this way the return on property equity as a driver for investment into care homes would be, at least in part, replaced by investment objectives more aligned to the needs of older people.

# Idea 15.

## Form A Company Of Companies So Smaller Actors Can Share Back Office Systems, Collaborate And Use This To Pass Commissioning Prequalification

Banding smaller service providers together to get economies of scale and to identify synergies, while maintaining what makes them unique, could assist in more people having access to, and so experience of, smaller scale service provision and so increase positive perceptions of such providers. One such effort currently underway is the Social Enterprise Procurement Consortium designed to bring smaller organisations together so they are collectively capable of bidding for public sector contracts.

### Opportunity Area: Develop Opportunities For Informal Service Provision Through Existing Providers

Tapping in to existing service provision, be it health, other statutory services or utilities providers is potentially an efficient and effective way of extending care provision into informal approaches we know older people respond well to.

# Idea 16.

## Enable GPs To Make Social And Non-Medicalised Prescriptions

GPs are reported to remain very much in the ‘old camp’ of medicine and care cultures with confidence in ‘fix and repair’ but not much else. As such, they are greatly underused and highly skilled assets sitting in the heart of every community. Over three quarters of GPs report they are seeing between one and five lonely older people a day, yet only 13

per cent said they were confident they could help a patient who was lonely[1]. While the GP him- or herself may not have a direct 'fix' for loneliness, there are hundreds of formal and informal services aiming to help with just this issue, across the country. Furthermore, people generally trust their GP, and a recommendation from a trusted expert to a particular intervention goes a long way to that intervention being taken seriously, and engaged with. To enable GPs to make social prescriptions, there would need to be:

- A free and easy resource for GPs (and general public) to identify what formal and informal services were available and relevant to older adults locally;
- An organisation formed that leads and develops this programme, to include:
- Evidence gathering of benefits from these local services;
    - Evidence gathering of benefits of non-medical and social prescriptions from early GP adopters;
    - A national training programme outlining the above to roll out to all GP services; and
    - Marketing and communications to general public of the new initiative.

# Idea 17.

## Use Non-Care Services, Such As BT Engineers, The Postman Or Supermarket Workers As Concerned And Caring "Community Members".

In keeping with the vision behind 'dementia friendly', this kind of programme could be classed as an 'older age-friendly' movement. Non-care services could empower their staff to consider the perspectives and challenges that might be faced by some of their older customers, with the aim of identifying those that may benefit from further support from formal or informal services. There is a great challenge with this of course - that care and concern oversteps into presumptuous and interfering interventions. But with the right training, and indeed the right channels and processes in place when concerns are raised, the vast network of non-care service staff could be a wonderful helping hand to more lonely and/or isolated older adults

1. (From the Campaign to End Loneliness, 2013)

## Opportunity Area: Incubate Micro-Enterprise

Small is beautiful. We need a lot more small and beautiful initiatives blossoming everywhere if we are to realise the Design Principle identified in this research.

# Idea 18.

## Support Community Catalysts To Replicate Their Approach Nationally

Community Catalysts harness the talents of people and communities to provide imaginative solutions to complex social issues and care needs through very small-scale non-traditional models of care and support. A simple but powerful way of scaling micro-solutions in the field would be to take Community Catalysts national.

## Opportunity Theme: Truly Value And Enable Older Adults On A Systemic Level

There are many organisations doing wonderful work in the space of valuing older adults and those who care for them. Yet they are a drop in the ocean when it comes to the formal and informal culture shifts that need to happen, in order for our society to truly be one in which the ageing process beyond retirement age can be at best an exciting new chapter of life, and at worst, comfortable. Furthermore, as we have seen, the existing organisations are not facilitated to be coordinated or to share learning. Segregation of 'old' (whatever that means) and young breeds prejudice, stigma and myth, and leads to an unhealthy practice of blame and further segregation when things go wrong. We need to integrate old and young, formal and informal relationships and services, and underpinning it all, we need to face up to the overwhelming fact that one day, each one of us will be 'old' too - which by default means we must face our fear of death.

Only then - when we see 'us' and not 'them' - can we think about the fundamental human rights that are at stake when it comes to living a good life, and just as importantly, dying a good death.

Our design principles are already manifested in people being treated as assets (thus behaving accordingly); giving power to individuals to own and design their own care pathway and care plan; family members included as equals where appropriate; and

building services that allow for compassion and empathy to flourish between participants. The following solutions we feel will further overcome the barriers identified and embody the design principles.

## Opportunity Area: Replace Current Care Planning Systems With A More Person-Centred Approach

"If it's not written down, it didn't happen," is part of everyday care home rhetoric. Well, do an audit of your average care provider's care plans, and you'll be hard-pushed to prove anything other than eating, drinking, washing, dressing, sleeping and using the toilet ever happens.

On the whole, care planning in institutional care does not work. While it is agreed that evidencing the wellbeing of an individual and the practice provided to support this wellbeing is undoubtedly important, the protocols that currently make up a care planning system are ineffective. At best, they bear witness to a never-ending stream of personal hygiene tasks, often completely disconnected from the real and sometimes excellent, person-centred practice that has taken place. At worst, they catalyse the destruction of relationship between care-giver and care-receiver, through de-humanisation of otherwise normal interactions, placing a burden of work upon a literary-shy workforce, and catalysing monotonous streams of creativity-free thought or action, for fear of retribution of 'big brother' who could one day, read everything.

Best in practice demands person-centred (and/or relationship-centred) care, yet our evidentiary systems promote exactly the opposite. So then, how can we evidence that we are trying to meet the wants and needs of a unique individual? And could there possibly be a way to quantify one's efforts to do so?

# Idea 19.

## Use Goal Attainment Scaling As The Backbone Of Care Planning

Goal Attainment Scaling (GAS) is a method of scoring the extent to which a person's individual goals are achieved over the course of an intervention. In effect, each person has his or her own outcome measure but this is scored in a standardised way as to allow statistical analysis. Traditional standardised measures include a standard set of tasks (items) each rated on a standard level. In GAS, tasks are individually identified to suit each person and the levels are individually set around their current and expected levels of performance.

# Idea 20.

## Build A Community Using Goal Attainment Scaling And Support Them To Become Champions Across The Sector

Goal Attainment Scaling (GAS) represents a potential transformation in care planning, monitoring and evaluation of services. Those individuals and organisations who use it are quickly convinced of its benefits. However the vast majority of care planning does not engage at all with GAS. In order to change this one strategy that might be used is to focus on getting uptake of GAS ubiquitous in a relatively small area or community and then using this to showcase, nationally, the benefits of this system.

### Opportunity Area: Harness The power Of 'People Helping People' For Better Support Following Dementia Diagnosis

If a consistently high and accurate diagnosis rate for a condition is achievable, but patients are left feeling abandoned, confused, and hopeless immediately following test results, is there any benefit to the diagnosis in the first place?

But what if after diagnosis, you are offered to have a cup of tea and a chat with someone in a nearby private room. Not a medical discussion, but one about the weather, or what type of biscuits you prefer. And one that gives you hope, because the lady or gentleman offering you the cuppa has been living well with dementia for a few years now, thus a beacon of hope and positivity to counteract all the fear and worry one typically feels upon hearing the big news. You would be invited to a network of people living locally with dementia and their carers, that you could contact at any time to learn more, potentially make friends and spend time with, and as you'd later learn, if you're so inclined, even help campaign to improve the world of dementia policy, products and services for the next generations.

# Idea 21.

## Work With And Build On The Dementia Engagement And Empowerment Project (DEEP) Groups' Models And Commission Peer-To-Peer Support Services On-Site At Dementia Diagnosis Services

The Dementia Engagement & Empowerment Project (DEEP) brings together groups of people with dementia from across the UK. DEEP supports these groups to try to change services and policies that affect the lives of people with dementia. Promoting DEEP could take a similar approach to the one proposed above under GAS.

### Opportunity Area: Provide The Tools That Allow People To Manage The End Of Their Lives

Only half of people who express a preference to die at home, actually die at home. 17% of people surveyed reported that decisions had been made about care that the patient would not have wanted. This pattern has remained unchanged since 2011[4][2].

There are two benefits to increasing the numbers of people that engage meaningfully in legally-binding 'living wills' (including advanced directives):

- More people will get the treatment they prefer near and at the time of death, and
- It encourages a person to engage in the philosophical and psychological space of realising our own mortality. If we actively explore how we would want to die well, it naturally follows that we would think about how we want to live well.

# Idea 22.

## Create A Living Will Website That Is Easy And Open To Access, And Legally Binding

The My Living Will project is creating a website to enable people to exercise choice and control at the end of life, for which existing guidance is quite inadequate. This website is intended to take the complexity and uncertainty out of writing a Living Will by taking users through a series of questions to understand their wishes and values. It then generates a Living Will that is tailored to the individual.

### Opportunity Area: Make Care Homes Sexy

Care homes are boring. Let's make them sexy! Sounds crazy, right? Well as Cocktails in Care Homes has proven it's not crazy at all!

# Idea 23.

## Roll Out Cocktails In Care Homes By Magic Me With A National Media Partner

Magic Me offers monthly evening parties at eight London care homes. The improvements in quality of life experienced by residents could, with relative simplicity, be scaled across

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2. [National Survey of Bereaved People, 2013].

London or even nationally.  This might be done by supporting Magic Me to scale or by developing a social franchising model that supports other organisations to take up the model.

### Oportunity Area: Valuing Those Who Care For Older Adults

Valuing professional older adult and dementia carers and specialists is central to achieving the transformation in service provision nationally acknowledged as needed. The sector needs proper career pathways where there are currently none. Salary levels need to acknowledge the importance of the activity and of the people – both carers and cared for. The sector, at a macro level and when looking at the detail, needs to be seen as valued by all stakeholders and society in general. It's a huge task, so let's break out a few ideas that could be described as realistic and achievable.

# Idea 24.

## Create A Teach First For Care

Teach First originated in the US as Teach for America and is now operating in countries across the world. It works by attracting high calibre graduates into teaching by presenting the challenge and the personal and professional development potentially derived from working in education. In this way it transforms the experience of students by providing a pipeline of excellent teachers into schools. Older person's care could be transformed by a similar approach to recruitment and retention of new staff into the sector.

# Idea 25.

## Campaign That Makes Caring Sexy

A coordinated media campaign that makes caring sexy could potentially improve perceptions about what is considered of value in relationships of care. This idea could develop in any number of directions: broadsheet and tabloid newspaper campaign, a television reality show, social media, etc. Finding a small group of media experts as supporters and matching them with some sector leaders would be the place to start in putting flesh on the bones of this idea.

# Idea 26.

## Generate A Living Wage Campaign In The Sector

Ensuring that all care professionals are not just on the minimum wage but at least on the living wage would cause a fundamental change in how carers saw themselves as valued and a commensurate change in the way they engage with the work, perhaps as a sub set of the Living Wage Campaign, or maybe as a campaign generated from within the sector.

## Opportunity Theme: Enable Current Systems To Step Up Provision Incrementally As Needed

We all know that prevention is better than cure, and that decision and change-making during crisis is costly – physically, emotionally and financially. Yet when it comes to older adult care we are still operating reactively. We need our systems to facilitate the approach of incrementally increasing support - and this works hand-in-hand with the preference for 'informal' and 'small'.

That way people can have the time to get used to changes of the physical and social environments around them - allowing them to co-design and feel valued also. In order to achieve this some of the fundamental aspects of service provision, such as housing or care pathway management, must shift away from short-termism and towards thinking strategically for a future of being there 'one step at a time', throughout the whole journey of ageing.

### Opportunity Area: Scale Admiral Nurses

Admiral Nurses (run by Dementia UK) are specialist dementia nurses, working in the community with people living dementia, their family members, and collaboratively with other professionals. They use a range of interventions that help people live positively with the condition and develop skills to improve communication and maintain relationships. Admiral Nurses meet the need, as reported by older adults, of having one expert point of contact for an individual with dementia, and their family, throughout the dementia journey. They provide the tools and skills to best understand the condition, as well as emotional and psychological support through periods of transition, and the ability to refer and liaise with other healthcare professionals on behalf of the family.

# Idea 27.

## Understand Why Admiral Nurses Have Not Scaled As Expected

An initial exploration into the reasons why the Admiral Nurse scheme has not scaled would need to be undertaken to understand what has worked, what has not and how to proceed in scaling.

# Idea 28.

## Replicate The Family Nurse Partnership Funding Model with Admiral Nurses

The Family Nurse Partnership has overseen a transformation in midwifery and social services provision to at risk mothers across the UK. It works by providing 50% of finances for a limited time, matched by the participating CCG, and requiring monitoring and evaluation to a level where, at the end of the two years, the CCG can clearly see whether the scheme has benefitted service provision, both financially and in care terms. This approach could potentially provide the incentive structure to scale Admiral Nurses and as such should be a priority to explore.

### Opportunity Area: Intervene In Existing Systems To Facilitate Incremental Care Provision

Housing, social services, work places, leisure facilities, social infrastructure: all are systems we engage with on a daily basis throughout our lives. But all are systems that rarely facilitate the incremental introduction of care services in ways that make for best practice and keep people away from crisis and away from intensive care environments for as long as possible.  The example of housing, below, could equally be applied to may other existing systems.

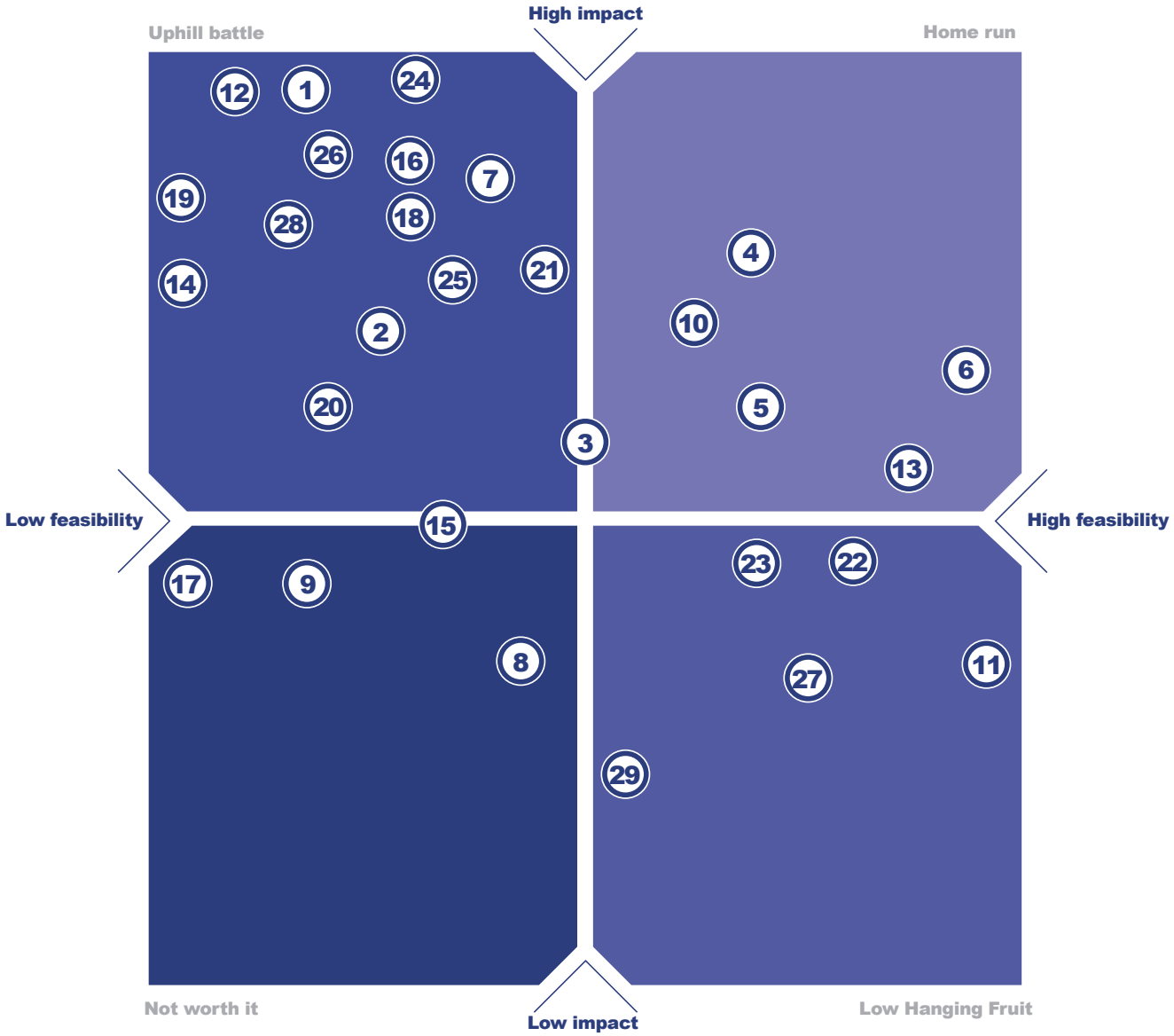
# Idea 29.

## Best Practice Exchange Across Housing Providers

Great housing providers retrofit to improve care capacity when properties are void. Poor housing providers miss this opportunity. Facilitating a best practice exchange to showcase the best in class work already underway might assist a wider uptake of such an approach.

## Opportunity Mapping

We evaluated these Opportunities along two important continuums: feasibility and impact. Feasibility is the likelihood that the idea can be implemented given resource requirements, regulations, social norms, learning curves, and other practical realities. Impact captures the ability of an idea to make a significant difference, through widespread adoption or influence. Together these assessments provide a rudimentary framework for identifying whether or not to move forward with the ideas.



# Next Steps

This research project has constructed a lens through which we can see the field of Ageing and Dementia Care in the UK. Opportunities and Ideas apart it is simply a tool, which can help make better sense of the sector. It sits alongside, and can be used in concert with, other attempts to coordinate and make sense of the field.

In terms of next steps we suggest the following modest initial steps:

- **Hold a small number of one to one meetings with key stakeholders.** Useful as a way to test the research findings, gauge future use of the work as a decision-making tool and to assess whether funders might resource future incubation or advisory work that builds on the research, we will seek to meet with no more than six key stakeholders to present the research findings.

- **Convene funders.** We'd like to see a group of funders convene to discuss the research and to explore what use they might make of it. Ideally this will be led by a funding body, perhaps The Big Lottery who is the original funder of this Bigger Boat initiative. Alternatives might be the Calouste Gulbenkian Foundation or the Henry Smith Charity, both of whom are convening funders who are focused on ageing and/or dementia.

- **Support uptake by existing constituency.** Many existing actors in the field would benefit from seeing the sector afresh through the lens of the landscape map. We will seek to meet no more than six organisations to present the research and work with them to interpret their existing activities and future plans through this lens.

Beyond these small steps, all of which can be undertaken with little additional resourcing, there are two more substantial activities that we see as worthy of development:

- Develop an advisory function. A mere glance at the landscape map reveals a lack of strategic thinking and coordination across the sector. Developing an advisory function, effectively a strategy and business development unit for the field, available to existing actors and new entrants could potentially improve and coordinate activity across the sector to realise increased efficiency and impact.

- Continue the work into the incubation phase of Bigger Boat. In-depth work over time to adapt and develop existing initiatives as well as to incubate some of the ideas identified in this work is naturally how the Bigger Boat process develops. If broadly acknowledged as a good idea by the above-outlined initial next steps we will seek substantial additional funding to run A Bigger Boat for Ageing and Dementia as a collaborative incubator for at least 18 months.

# Appendix: Interviewee Profiles

Profiles of interviewees are presented alphabetically. Interviews were conducted between March and September 2014.

## Helen Allen, Operations Manager, Community Catalysts

Helen began her career in the social care field before moving to Shared Lives, a project of Community Catalysts, where she managed the scheme and developed it into a generic service. Helen now works with a variety of Council and Health Authorities to stimulate and sustain local micro markets for people in those areas, and supporting organisations to develop their own Shared Lives Schemes. Community Catalysts harness the talents of people and communities to provide imaginative solutions to complex social issues and care needs through very small-scale non-traditional models of care and support. They are passionate about bringing choice of high quality, small-scale local services to people wherever they live. Community Catalysts runs Small Good Stuff, a network which links people, organisations or groups who offer support, care or services to people in their local community on a very small scale with people who need care or support to live their life. Small Good Stuff offers very small organisations that offer support, care or services to people in their local community information, advice and resources.

You can find out more at: http://www.communitycatalysts.co.uk

## Stuart Arnott, Founder, Mindings

Stuart Arnott has a long-standing background in multi-media production. It was when Stuart's Mother became ill that a new venture arose that today Stuart runs called Mindings. Mindings is a private social network that shares content on a digital screen in a person's home. It connects socially isolated people to their family, friends and community, and provides reassurance that they're okay. Rather than sensors and devices that monitor and track an individual's wellbeing Mindings sits 'near ambient' within a person's home, and lets the individual engage with it on their own terms. Mindings is also working to connect people with similar interests together, and local community members together, all to support the wellbeing of more isolated older adults. "Mindings" is actually a real word; "a small gift or token of goodwill, often of little or no value, given to the recipient simply to let them know they're being thought of".

You can find out more at: http://www.mindings.com

## Ben Atkinson-Willes, Active Minds

Active Minds grew from experience, knowledge and a desire to improve the quality of life and relationships for people living with dementia, and those caring for them. Ben Atkinson-Willes experienced firsthand what it's like to care for a loved one with dementia. Ben was a design student at Kingston University when his grandfather developed Alzheimer's disease. He very quickly found that there was a lack of suitable activities available for people and carers living with dementia. This meant families and carers would usually resort to using children's toys to provide stimulation to those they cared for. However, these were not age-appropriate and were therefore unsuitable. For this reason Ben created a range of activities as part of a University project for adults living with dementia. He was offered funding by the University to turn it into a business venture and so Ben founded Active Minds.

You can find out more at: http://www.active-minds.co.uk

## Professor Clive Ballard, Kings College London

Professor Clive Ballard is an old-age psychiatrist working at Kings College London. He and collaborators are currently undertaking a systematic review of person-centred care interventions and training manuals for use with people with dementia in care homes. Professor Ballard looks at ways to improve quality of life and wellbeing but also ways of improving psychiatric symptoms.

You can find out more at http://www.kcl.ac.uk/ioppn/depts/wolfson/about/people/staff/ballardclive.aspx

## Claire Bamford, Senior Research Associate, Institute of Health & Society at Newcastle University

Claire was part of a three-year research collaboration across three universities to address the problem of malnutrition in older patients. This was done by exploiting new and existing technologies to rethink and test new ways that food can be produced and delivered to older patients using a 'a joined-up' approach that considers all stages of the food journey from production to consumption (i.e. products, people, places and procedures). The outcome was Hospital Foodie.

You can find out more at: http://www.hospitalfoodie.com

## Andy Bradley, Founding Director, Frameworks4Change

Andy started as a care worker mostly in the lives of people with profound and multiple learning disabilities and later as a manager in local authorities before founding Frameworks4Change. Frameworks4Change is a training and consultancy business with a focus on building trust, safety and co-operation primarily in the health and social care sectors. The organisation places compassion at the heart of their work. A programme may comprise: support for leaders to reflect on compassionate leadership in high pressure environments; compassionate practitioner training for ward level leaders; developing core compassion skills; seminars for front line staff; and an on-site audit tool. The aim is to build a culture of compassion to transform the way teams work together and leaders behave in service of a consistently caring and person-centred response to people with dementia and their families.

You can find out more at: http://www.frameworks4change.co.uk

## Professor Carol Brayne, Director, Cambridge Institute of Public Health

Professor Carol Brayne is Professor of Public Health Medicine in the Department of Public Health and Primary Care in the University of Cambridge. She is Director of the Cambridge Institute of Public Health. Her research focuses on Public Health, Ageing and the Brain. Carol is a medically qualified epidemiologist and public health academic.
Since the mid eighties her main research area has been longitudinal studies of older people following changes over time in cognition, dementia natural history and associated features with a public health perspective. She is lead principal investigator in the group of MRC CFA Studies, which have informed and will continue to inform national policy and scientific understanding of dementia in whole populations. She has been responsible for training programmes in epidemiology and public health for under and postgraduates since the early nineties.

You can find out more at: http://www.iph.cam.ac.uk

## Beth Britton, Blogger, Independent Consultant

Beth spent 19 years helping to care for her father who lived with vascular dementia. During her father's dementia she experienced a myriad of health and social care services that varied from excellent to exceptionally poor. What all of those experiences had in common, however, was what could be learnt from them to improve knowledge, awareness and care for all. In May 2012 Beth launched D4Dementia, a blog aimed at providing support and advice to people faced with similar situations to those we lived through with my father, inform and educate care professionals and the wider population, promote debate and create improvements in dementia care. Beth is now a campaigner, consultant and writer on dementia care.

You can find out more at: http://www.bethbritton.com

## Ralph Broad, Director, Inclusive Neighbourhoods

Ralph has more than 25 years experience in working alongside people who may be vulnerable due to age, disability, mental health needs, sensory impairments, their families and local communities. Inclusive Neighbourhoods values the inherent strengths, capacities and contribution of all people in society. It works in partnership with individuals, families and local communities to support them to pursue and realise their vision for a good life and to create stronger, more welcoming communities. Inclusive Neighbourhoods also works with local authorities, statutory services, local communities and provider organisations to reimagine the possibilities of how services can become more personal, flexible, accountable and efficient. Local Area Coordinators (LACs) start to get to know individuals and their families and build up a picture of the local community and its networks. Generally people are viewed as passive recipients of care and support packages, which don't often even meet the stated needs or aspirations and do not build personal reliance. LACs turn the system on its head, intentionally helping the individual to build their own capacity with friends, family and neighbours using the local resources and using formal systems as the last port of call.

You can find out more at: http://inclusiveneighbourhoods.co.uk

## Dawn Brooker, Founder and Director, University of Worcester Association for Dementia Studies

The Association for Dementia Studies (ADS) at Worcester University, which aims to make a substantial contribution to building evidence-based practical ways of working with people living with dementia and their families that enables them to live well. This is done primarily through research, education and scholarship. Dawn has a background in clinical psychology and she worked for several years at Bradford Dementia Group having been the world expert on Dementia Care Mapping.

You can find out more at http://www.worc.ac.uk/discover/association-for-dementia-studies.html

## June Burgess, Regional Coordinator UK & Ireland, Eden Alternative CIC

June Burgess is a registered nurse with a background in healthcare management and quality assessment in aged care. The Eden Alternative is an organisation dedicated to improving the experience of aging and disability throughout the UK. It is a powerful tool for improving the quality of life for residents and for recapturing a meaningful work life for staff. The Eden Alternative shows how true companionship, the opportunity to give meaningful care to other living things and the variety and spontaneity that mark an enlivened environment can succeed where pills and therapies fail.
You can find out more at: http://www.eden-alternative.co.uk
Sarah Caplan, Director of Development and Communications, Silverline
The Silver Line is the confidential, free helpline for older people across the UK open every day and night of the year. Specially trained helpline staff offer information, friendship and advice; link callers to local groups and services; offer regular befriending calls; and protect and support those who are suffering abuse and neglect.

You can find out more at: http://www.thesilverline.org.uk

## Georgina Craig, Experience Led Commissioning within Georgina Craig Associates

Georgina Craig Associates (GCA) is a social business that works to create a people centred NHS. GCA believes that no matter where people are on life's journey, they deserve to be as healthy and happy as they can be – and that by focusing on and deeply understanding their perspective, GCA's clients can support this. GCA conceptualised the trademarked, innovative, experience-led commissioning (ELC) approach and has been working in partnership with researchers at The University of Oxford's Health Experience Research Group, Kings College and with our trailblazing commissioning partners to prototype ELC. ELC provides a new way of approaching commissioning, service redesign and whole system change, which is evidence based and driven by the ambition to deliver a fantastic care experience. It resonates perfectly with the NHS's ambition to deliver 'no decision about me without me' and fills a significant gap in 'know how' for CCGs.

You can find out more at: http://gcraigassociates.co.uk

## Jenny Davison, Elders Voice

Jenny is the Chief Executive of Elders Voice. Elders Voice works with over 2,000 older people across Brent each year and has been doing so since 1993. Elders Voice provides practical, emotional and social opportunities to people ranging in age from 55 years to over 100. The services are therefore as varied as the people who use them.

You can find out more at: www.eldersvoice.org.uk

## Cath Dillon, Associate, Participle

Cath has worked for over 20 years in a wide range of leadership roles across the voluntary and community sector including Action for Children and Macmillan Cancer Support as well as locally with Community Links in East London, Citizen's Advice and Women's Aid in West Yorkshire. Participle works with and for the public to create new types of public services that make a real difference in everyday lives. The Circle movement is one of these services. Circle is an innovative membership-based service, open to anyone over the age of 50, supporting individuals and communities to lead the lives they want to lead. Members are supported across four areas of their lives: social activity, life's practical tasks, tailored learning and appropriate health and wellbeing services. At the heart of Circle is a fundamental belief that everyone has the right to a flourishing, independent later life. Circle enables people to make progress that is meaningful to them, to do things that they value and to develop new relationships and innovative support systems of their own. Circle does this by embedding deeply in the localities where we operate. We realise the potential and capacity of our local community to develop new services and to reconfigure existing ones in response to people's aspirations and desires.

You can find out more at: www.circlecentral.com

## Andrew Van Doorn, Deputy Chief Executive, Housing Associations Charitable Trust

Andrew joined HACT in 2003 and has worked in homelessness, supported housing and wider social exclusion policy and practice for 19 years. He has recently completed an 18-month secondment to the National Mental Health Development Unit working on the cross government social exclusion agenda. Founded in 1960, but re-launched in 2012 with funding and support from a range of leading housing providers, HACT is a charity, social enterprise and industry-focused think/do tank established by the housing association sector. HACT's aim is to work with the housing sector, government, civil society and communities to develop and share innovative approaches to meeting changing needs. HACT seeks to influence and innovate in ways which help all housing providers deliver more effectively within their communities.

You can find out more at: www.hact.org.uk

## Simona Florio, Coordinator, Healthy Living Club

The Healthy Living Club is a self-directed, dementia-centred community meeting weekly in Stockwell, London, originally founded by Simona. The group meets for four hours each week for a programme of activities developed to alleviate the symptoms of dementia and to promote the mental and physical wellbeing of those people with the illness. Each meeting is

run as a social event, which people attend to meet each other, have a good time and share experiences.
The Club is run with a team of volunteers and some sessional contributors. It is seen as a blueprint for future dementia care in the community.

You can find out more at: http://healthylclc.blogspot.co.uk

## Chris Gage, Managing Director, Ladder To The Moon

Chris is a social entrepreneur and organisational development practitioner with a background in community and engaged theatre practice. He has pioneered the unique approach of Ladder to the Moon in order to lead and support the change that he wanted to see in the services that his Grandmother used. Ladder to the Moon provides workforce and service development that enables health and care organisations to develop active, creative, vibrant care services. By working with Ladder to the Moon, organisations improve activity culture and quality of life outcomes, achieve high levels of staff engagement and differentiate themselves in the marketplace.

You can find out more at: http://www.laddertothemoon.co.uk/

## Helen Goulden, Executive Director, Nesta Innovation lab

Helen is Executive Director in Nesta's Innovation Lab, where she oversees the design and delivery of programmes to test new models for supporting and scaling social and environmental innovation with a particular focus on digital and open innovation. Before joining Nesta, Helen worked in the private sector developing digital strategies and solutions for global corporate clients. She spent five years consulting in the Cabinet Office, Office of the Deputy Prime Minister and Communities and Local Government developing national innovation programmes for local government and leading research and product development for interactive television services.  Helen has a particular interest in sustainability, the future of food, agro-forestry.

You can find out more at: www.nesta.org.uk

## Paul Hodgkin, Founder and Chair, Patient Opinion

Paul founded Patient Opinion in 2005 and it's now the UK's leading independent non-profit feedback platform for health services. Patient Opinion is about honest and meaningful conversations between patients and health services, and believes that patient's stories can help make health services better.

You can find out more at www.patientopinion.org.uk

## Clea House, Community and Communication Manager, Magic Me

Clea has 10 years experience in small arts organisations, including two years working in World Music festival production and events organising with the charity Cultural Cooperation. Magic Me is an arts charity that brings the generations together to build a stronger, safer community. Projects often link unlikely partners, for example young people aged 8+ and adults aged 60+ team up through shared, creative activity. Intergenerational groups meet on a weekly basis in schools, museums, older peoples clubs, care homes, community and cultural organisations. In particular Magic Me's programme of Cocktails in Care Homes has

gained national acclaim. It's popular because everyone feels like they get something out of it, and hundreds of volunteers have asked to be part of the programme in London. This includes a majority of young, working adults, who typically don't volunteer or have access to the care home system. But Cocktails in Care Homes makes the volunteering fun and feasible, because it's after the working day, which is unusual.

You can find out more at: www.magicme.co.uk

## Ken Howard, Independent

Ken was diagnosed with Alzheimer's disease about five years ago in his mid-50s. Ken gives talks in local schools about dementia and is an Alzheimer's Society Ambassador. He has spoken at a number of public events about dementia and is passionate about increasing awareness.

You can find out more at: https://twitter.com/kenhowarduk

## Roger Jones, National Manager, Older Men's Network

Roger is an expert in older men's health and how to engage older men. As National Manager he is responsible for the development of the Older Men's Health Network, including partnerships, projects, volunteer development and training. The Older Men's Network is a network designed to give as much information and support to individuals and organisations that want to make a difference to older men's health and wellbeing. It works across three main themes: physical activity; mental wellbeing and healthy eating. Developed from the National Fit as a Fiddle project funded through Age UK and The BIG Lottery Fund, the Fit as a Fiddle Older Men's Project has supported older men and organisations across the UK.

You can find out more at: http://oldermenswellbeing.co.uk

## John Kennedy, Director of Care Services, Joseph Rowntree Housing Trust

John is Director of Care Services at Joseph Rowntree Housing Trust (JRHT) and currently manages a mixed portfolio of housing providing care in York, Leeds, Scarborough and Hartlepool. The JRHT acts as the landlord for the rented property and supports the community and educational activities in the village. It also carries out housing schemes in York and elsewhere in Yorkshire. These are of a developmental nature, demonstrating new forms of tenure, meeting special needs and exploring new features of design.

You can find out more at: http://www.jrf.org.uk/about-us/joseph-rowntree-housing-trust

## Ilyanna Kerr, Co-founder, See What I Mean

Ilyanna (CEO) is a designer working across interaction, visual communication and service design. She has worked at leading design consultancy Pentagram for clients including Maggie's Cancer Care Centres, the Science Museum, Saks Fifth Avenue and the Royal Academy of the Arts. The See What I Mean app is a speech to image communication tool for those of us living with dementia.

You can find out more at: www.seewhatimean.co.uk

## Dan Lehner, Chief Product Officer, Oomph!

Dan Lehner is the Chief Product Officer at Oomph!, which exists to transform the quality of life of older people everywhere through fun, inclusive health and wellness programmes including chair cheerleading and chair aerobics. Oomph! provides group-based, interactive exercise therapy classes for over 65s that improve mobility, social interaction and mental stimulation. Best-in-class research tools to track and map health and wellbeing outcomes, enabling individuals and organisations who work with older adults to better understand what works and why.

You can find out more at www.oomph-wellness.org

## Alison Macadam, Project Manager, NDTi

Alison's main area of work is currently project managing the Circles of Support for People with Dementia project. Alison has worked in the voluntary and community sector since 2004. The National Development Team for Inclusion (NDTI) is a not-for-profit organisation concerned with promoting inclusion and equality for people who risk exclusion and who need support to lead a full life. NDTI has a particular interest in issues around age, disability, mental health and children and young people. NDTI's main aims are to: shape and influence policy and public debate; Enable a stronger voice of people to be heard; Support services to work differently so that they promote inclusive lives; Support communities to be welcoming and inclusive.

You can find out more at: www.ndti.org.uk

## Professor Neil Maiden, Head of Centre For Human Computer Interaction (HCI) Design, Co-founder of the Centre for Creativity in Professional Practice at City University London

Neil has published research in over 160 peer-reviewed publications, and won and led research worth over £3 million as part of research projects collectively worth over £35 million. The Centre for HCI Design generates research, teaches, consults and provides business services focusing on the relationship between people and innovative technology with the aim of creating more useful and usable systems. Recent EU funding led to the HCI Centre researching and developing mobile applications focused on the relationship between creative problem solving and learning tailored to workers caring for older adults, including people living with dementia, in care homes. The apps facilitated carers to provide person-centred care by enabling the individual carer to have more control over what information was learned, shared or imparted, when and where. The carers reported feeling more confident and autonomous in evidencing their good practice, finding solutions to complicated scenarios and creating plans of care that had the benefit of creative and holistic thinking through reflective practice, as prompted by the applications. Neil is currently founding a new consultancy called Creative Care Consultancy supported enhanced care practice in care homes.

You can find out more at: http://www.city.ac.uk/centre-for-creativity-in-professional-practice and www.creativecareconsultancy.com

## Neil Mapes, Director, Dementia Adventure

Neil Mapes wanted to solve the problem of how you go about having a life worth living while living with a terminal illness. In 2011 Neil and Lucy Harding, with a unique combination of skills and experience of over 30 years in both dementia care and the adventure travel industries between them, founded Dementia Adventure. Dementia Adventure connects people living with dementia with nature and a sense of adventure. They provide training, research, and consultancy services - all with nature in mind. They work in partnership with individuals and organisations across the UK so that all people living with dementia can have a sense of adventure in their lives regardless of where they live.

You can find out more at: www.dementiaadventure.co.uk

## Rachel Massey, Manager, Culture Club

Rachel Massey is the Manager at the Culture Club, the club designed to bring the best of culture to over 55''s in the Kirklees area. The programme of workshops, events and special occasions are designed to stimulate mind, body and soul with something for every taste. The club is passionate about the potential of the arts and culture to enhance the lives we live and the places we live and work in.

You can find out more at: www.culture-club.org.uk

## David Metz, Independent

David is a visiting professor in the Centre for Transport Studies at UCL. He is also interested in ageing and finance issues and currently leads on a project called My Living Will. This web tool is intended to take the complexity and uncertainty out of writing a Living Will by taking users through a series of questions to understand their wishes and values. It then generates a Living Will that is tailored to the individual. David was formerly Chief Scientist at the Department for Transport, and before that a member of the scientific staff at the Medical Research Council and a civil servant in various Whitehall departments.

You can find out more at www.davidmetz.org

## Julienne Meyer, My Home Life

Professor Julienne Meyer leads research in Care for Older People at City University London, and is Executive Director of My Home Life Programme (MHL). Julienne initially trained as a nurse, and today has an international reputation for expertise in appreciative action research, which uses participative and affirming methods to research attempts to improve practice. MHL is a collaborative movement of people involved with care homes for older people. It seeks to improve the quality of life of everyone connected with care homes for older people and has now become the recognised voice for the sector which promotes best practice through appreciative support and transformative action.

You can find out more at: http://myhomelife.org.uk

## Peter Molyneux, Founder, Common Cause Consulting

Common Cause Consulting was founded by Peter Molyneux to facilitate positive, practical organisational partnerships between housing and health. Peter is Chairman of the SW London and St Georges Mental Health Trust. He is leading a multi-sectoral programme to co-produce innovative solutions to complex issues at the Dementia Services Development Centre, the City of London Corporation and Public Health (England).

You can find out more at: www.commoncauseconsulting.co.uk

## Marc Mordley, Director, Vintage Communities

Marc Mordey has been the Chief Executive Officer of two charities and a senior manager within the NHS (mental health services). The vision of Vintage Communities is to facilitate a movement of people committed to developing connected and caring communities which bring together young and old to find local solutions to local problems and in the process develop social networks and a sense of being valued and part of the community. Vintage Communities uses the Asset Based Community Development (ABCD) approach to develop and support older people as community connectors. These community connectors use their skills and experience to help develop connected neighbourhoods, which are inclusive and make the most of the community's assets.

You can find out more at: www.vintagecommunities.co.uk

## Rachel Mortimer, Founder and Director, Engage & Create

Engage & Create is a not-for-profit organisation working to improve quality of life for people with dementia and those that care for them. Rachel has a Montessori Diploma with distinction and is completing a BSc in Psychology. She is a professional artist and has worked as a carer. Rachel's nurturing workshops revive life skills and improve mental condition, helping and inspiring participants to remember, reminisce and rediscover forgotten aspects of their lives. Engage & Create believes involvement in art enables participation in a meaningful, intellectual activity and opportunity for personal growth. Delivered through the Montessori approach focusing on individual's strengths and abilities, this positive approach to dementia care is a source of creativity and comfort to people with dementia and caregivers alike.

You can find out more at: www.engageandcreate.co.uk

## Simon Pedzisi, Director of Care Services and Leon Smith, Executive Vice President, Nightingale Hammerson

As Director of Care Services, Simon's Key role is leadership strategy, planning, vision and compliancy with regulation, care governance and quality assurance. He is also the registered manager with the CQC for Nightingale House. Leon is in charge of fundraising, PR and advertising. Before this role Leon was CEO of Nightingale House for over ten years. Nightingale Hammerson is an independent charity, which has been serving the community for over 170 years. The organisation's approach to care is holistic and they are passionate about providing person-centred care. They are also unique in their approach to workforce development strategies and breadth of partnerships with providers, educators and community organisations.

You can find out more at: www.nightingalehammerson.org

## Gill Phillips, Founder and Director, Whose Shoes

Gill Phillips worked in a variety of roles at Coventry CIty Council before starting her own business; Nutshell Communications. Gill is recognised as a perceptive thinker, skilled at highlighting barriers and inconsistencies in policy and practice and devising innovative ways to engage and inspire people. She gives lively, challenging talks and workshops across the UK and is a champion of involving 'experts by experience' and using innovative co-production approaches. Her 'Whose Shoes' products and services help you get to the heart of what is important in communication and co-production. Instead of wrapping things up in jargon and complicated language, messages are honest, direct and simple, sourced from what real people are saying.

You can find out more at: http://nutshellcomms.co.uk/

## Sarah Reed, Founder, Manny Happy Returns

Sarah Reed has a background in media and design, but when her mother had Alzheimer's disease and vascular dementia for ten years Sarah found a new passion in the care of and quality of life of people with dementia. As a core team member of My Home Life, Sarah conceived of and led the 2012 Big Care Home Conversation, and continues to work with them on key communication projects. Sarah's current role is as founder of Many Happy Returns - innovative, evidence-based memory-based products to connect young and old – especially those with dementia, more meaningfully. These include reminiscence cards which help people to connect with pleasure through shared stories and memories, and REAL Communication workshops (Gold Award, The Learning Awards 2014) to help improve carers' communication skills through interactive learning. The resulting attitudinal changes deliver better relationships for residents, families and staff teams and improvements in wellbeing and self-esteem for old and young alike.

You can find out more at: www.manyhappyreturns.org

## Catherine Ross, Editor, Journal Of Dementia Care

Catherine Ross has a background in social care work and has been editor of the Journal of Dementia Care (JDC) since 2005. The JDC is a multidisciplinary journal aimed at all professionals working with people with dementia. It showcases best practice from a full range of professionals working in dementia care to share learning. It aims to provide a strong editorial commitment to improving the quality of care provided for people with dementia; to raise the profile of all professionals working in this specialist field; to present the ideas and opinions of professionals working with people with dementia; and to emphasise the value and importance of training and staff development to achieve high quality care.

You can find out more at www.careinfo.org/journal-of-dementia-care/

## Catherine Russell, Programme Manager, Nesta

Catherine Russell is a Programme Manager in Nesta's Innovation Lab focused on ageing and health. This includes the Innovation in Giving Fund and the Centre for Social Action's focus on impact volunteering to improve outcomes for older people and those with long-term health conditions. Nesta is an innovation charity with a mission to help people and

organisations bring great ideas to life. Nesta are dedicated to supporting ideas that can help improve all our lives, with activities ranging from early stage investment to in-depth research and practical programmes.

You can find out more at: www.nesta.org.uk

## Kay Russell, Strategic Planning Manager, Bristol City Council

Kay is the Strategic Planning Manager of Health and Social care at Bristol City Council. Kay has a diverse background in commissioning, care home provision, the voluntary sector and improving social care services. Her current work is with organisations that focus on community development to alleviate social isolation. A recent piece of research looked at the impact of social isolation on wellbeing, found to be as bad as being an alcoholic or smoking. It emerged that one of the big risk groups of older adults were those living in care homes.

You can find out more at: www.bristol.gov.uk

## Nada Savitch, Innovations In Dementia CIC

Nada Savitch has a background in information work. She has provided support and training to groups of people with dementia who were interested in using computers. She also worked on a consultative basis with people with dementia to design websites and to develop new and accessible computer software. Innovations in Dementia works nationally with people with dementia, partner organisations, and professionals with the aim of developing and testing projects that enhance the lives of people with dementia. Outcomes from such projects will influence approaches to dementia care and support in order that they are more creative, positive and enabling. Innovations in Dementia believes that people with dementia should: be able to experience all that life has to offer; receive appropriate and sensitive support to access opportunities and learn new skills; and be part of opportunities and decisions that affect their lives.

You can find out more at: www.innovationsindementia.org.uk

## Sylvia Silver, National Activity Provider Association

Sylvia is the director of National Activity Provider Association (NAPA), which supports front line care staff to enable older people to live life the way they choose with meaning and purpose. NAPA is a small, unique national charity with care home membership. NAPA provides a quarterly magazine, training, consultancy and audit services, and runs a helpline Monday to Thursday. Sylvia has been the director for 10 years, taking the organisations from just 300 to 3,000 care home members.

You can find out more at: www.napa-activities.co.uk

## Deborah Sturdy, Director, Red & Yellow Care

Deborah has worked in health and social care for over 30 years. She has held a number of posts working with older people and people living with dementia. These have included clinical practice, management in a range of health settings and spent three years as a researcher at the University of Kent working on long term care assessment as part of an

international collaborative. She was the Government Nurse Advisor for Older People for 10 years providing leadership to the profession and contributing to a range of national policy including the National Service Framework for Older People and The National Dementia Strategy. During this time she advised on a number of stakeholder groups.
Currently she works as an independent consultant and is a Director at Red & Yellow Care, which offers specialist support for people living with dementia. Red & Yellow's multi-disciplinary team uses the latest clinical evidence, patient research and understanding of the condition to provide the very best diagnostic assessment, care and support available in the UK.

You can find out more at: http://redandyellowcare.com

## Rachel Thompson, Professional & Practice Development Lead, Admiral Nursing

At the time of interview Rachel was the Dementia Project Lead at the Royal College of Nursing. Today Rachel is in a new role with Dementia UK as the Professional & Practice Development Lead for Admiral Nursing. She is also the Chair at the Higher Education for Dementia Network. Admiral Nurses (Dementia UK) are specialist dementia nurses, working in the community with people living dementia, their family members, and collaboratively with other professionals. They use a range of interventions that help people live positively with the condition and develop skills to improve communication and maintain relationships. Admiral Nurses meet the need, as reported by older adults, of having one expert point of contact for an individual with dementia, and their family, throughout the dementia journey. They provide the tools and skills to best understand the condition, as well as emotional and psychological support through periods of transition, and the ability to refer and liaise with other healthcare professionals on behalf of the family. To this end they can alter the levels of support meet the usually incrementally increasing needs of the individual and their family.

You can find out more at: www.dementiauk.org/what-we-do/admiral-nurses/

## Toby Williamson, Lead in mental health in later life and dementia, and mental capacity at the Mental Health Foundation.

Toby has over 20 years' experience of working in the field of mental health where he has been involved in setting up, working in and managing a variety of services in both statutory and non-statutory organisations for people with severe and enduring mental health problems living in the community. The Mental Health Foundation conducts research and practical evaluation to recognise the key issues affecting the nation's mental health and wellbeing, and uses this knowledge to: improve policy and practice in mental health; campaign to raise awareness and remove stigma; provide high quality advice and information to help people better manage their mental health and wellbeing; provide practical solutions to improve the quality and access to mental health services in the UK.

You can find out more at: www.mentalhealth.org.uk

o-founded the Memory Apps for Dementia partnership in 2010. Alive! is a charity dedicated to improving the quality of life for older people in care by enabling their participation in meaningful activity, through workshops, training, projects and advocating.

## Tim Lloyd-Yeates, Founder and Director, Alive!

Tim creates and facilitates Alive! sessions in the Bristol area. Three members of his immediate family have lived in care. He is passionate about empowering older people, especially those now living in residential care and is campaigning for care home residents to have access to their interests, access to activities and a guaranteed rich quality of life. He is also the acknowledged innovator of using iPads with people living with dementia and c o-founded the Memory Apps for Dementia partnership in 2010. Alive! is a charity dedicated to improving the quality of life for older people in care by enabling their participation in meaningful activity, through workshops, training, projects and advocating.

You can find out more at: www.aliveactivities.org

# Appendix: Project Team

## Alise Kirtley

Alise entered the older adult and dementia care sector as a Change Manager of a large care home practice development project in a knowledge transfer partnership with Bradford Dementia Group. With an academic background in physics and music and a prior career in social enterprise development, Alise has an analytical mind and fresh perspective with an appetite for challenging “the way things are done around here” when it comes to institutionalised care. She is now an independent consultant working in a variety of projects that seek to develop practice, change culture and use innovative technologies to improve the quality of older adult care services.

For more information on Alise visit www.alisekirtley.org

## Ben Metz

Ben Metz is a psychoanalytic organisational consultant and serial social entrepreneur. He is founder of Bigger Boat.  Through Bigger Boat Ben works with, and creates environments for, leaders and their organisations so they may do good better. Through his consulting work he assists people to improve their understanding of organisational dynamics in order to effect change and instigate new behaviours and innovations.

For more information on Ben visit www.benmetz.org


www.biggerboat.org
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