Exploring the impact of intergenerational activity programmes on those living, visiting and working in care homes across South Wales

Katherine Elin Howson

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Abstract

Background: Policies advocating the development of age friendly communities acknowledge that the integration of people living with dementia in care homes needs to improve. Intergenerational programmes were developed as a promising method to bridge the generation gap and to reduce inactivity, isolation and loneliness for older people in care homes. To date, there is little robust evidence on the impact on younger people, older people and care staff in the UK. The key mechanisms of delivery have not been articulated. This study was designed to address this gap.

Methods: Older adult residents (n=97) including those with cognitive impairment), younger people (n= 96) and care staff (n= 53) participated in a mixed methods longitudinal quasi experimental evaluation. Primary outcomes included older adults quality of life, younger people's attitudes towards older adults with dementia, and care staff job satisfaction. Personal experiences and the mechanisms of impact of the intergenerational activity programmes were also explored. Data were analysed statistically and thematically.

Results: Intergenerational activities improved older adults quality of life through engagement in meaningful activity and development of relationships. These effects were sustained through the creation of objects that aided reminiscence. Younger people's attitudes towards older adults was enhanced. Care staff showed no significant quantitative changes in job satisfaction however qualitative data highlighted an increase sense of purpose amongst activity co-ordinators. Relationships, rather than the activities themselves were central to the success of the intergenerational activity programme.

Conclusions: Intergenerational activity programmes delivered in care homes offer benefits to residents, younger people and care staff, creating environments in which meaningful relationships could develop. Whilst intergenerational activities offer a potential solution to some of the challenges in delivering social care in Wales, care staff attitudes towards delivering activities, and inadequate staffing levels remain a barrier to rolling out.

Key words: Intergenerational, Care Home, Quality of life, Dementia, Care staff, Younger people, Older Adults

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a. STATEMENT 1

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List of abbreviations

IG : Intergenerational

IP: Intergenerational program**me**

IAP: Intergenerational activity programme

CH: Care home

OA: Older adults

YP: Younger people

CS: Care staff

MOCA: Montreal cognitive assessment

ADL: Activities of daily living

GDS: Geriatric Depression Scale

QOL: Quality of life

DEMQOL: Dementia quality of life

EMAS: Engagement in Meaningful Activities Survey

GDS: The Geriatric Depression Scale

MJS: Measure of job satisfaction

ADQ: Approaches towards dementia questionnaire

CWEQ-II: Conditions for work effectiveness questionnaire two

SDCS: Strain in Dementia Care Scale

CATE: Children's attitudes towards ageing

SD: Standard deviations

SI: Symbolic interactionism

T1 – Time point one

T2 – Time point two

T3 – Time point three

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List of key terms

Generation - This study focuses on intergenerational activity programmes involving individuals from societal generations. Generations at a societal level, share three key components: shared birth period, shared exposure to common historic events and shared socio-cultural location (Gilleard and Higgs, 2002).

Intergenerational Practice: 'aims to bring people together in purposeful, mutually beneficial activities which promotes greater understanding and respect between generations and contributes to building cohesive communities. Intergenerational practice is inclusive, building on the positive resources that the [different generations] have to offer each other and those around them' (Beth Johnson Foundation, 2001)

Residential care home: Residential care homes provide accommodation as well as 24-hour personal care and support for older people and adults who struggle to live independently, but do not need nursing care.

Nursing home: A nursing home provides residential accommodation as well as healthcare for people who are unable to receive sufficient care at home and do not need to go into hospital.

Dementia: describes a broad set of symptoms, including memory loss, impaired reasoning and language difficulties.

Quality of life: An individuals' perception of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns.

Social Isolation: The absence or low levels of social contacts

Loneliness: "situation experienced by the individual as one where there is an unpleasant or inadmissible lack of (quality of) certain relationships" (De Jong Gierveld, 1998).

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I hope this research will make a contribution to Welsh care communities, the wider intergenerational literature and beyond.

1. Chapter One - Introduction

6.1. Thesis structure

Overall this thesis is divided into eight chapters. This current chapter provides a brief background and rationale for the rise of intergenerational practices and intergenerational activity programme (IAP) as a concept, related outcomes and issues. Following, the main aims and content of each chapter are summarised.

Chapter two provides a detailed insight into the contextual factors from which intergenerational practice and IAP as concepts have arisen. It looks at contextual influences in terms of demographic change, changes within society, familial dynamics and structures, as well as the position of intergenerational practice in the political arena. It examines the theoretical development of intergenerational practice and how frameworks used to date may limit insight into the mechanisms by which intergenerational practice generates and sustains outcomes.

Chapter three reviews the content of the intergenerational literature to date. It starts by outlining key terms and definitions used in the study, before presenting findings of a general scoping review of intergenerational practice. The chapters focus then shifts to a more targeted literature review of intergenerational activity programmes (IAP) conducted within care settings. In doing so it highlights key potential outcomes that have been identified to date as well as exploring elements of best practices and processes that potentially drive particular outcomes. Throughout this chapter gaps in research and methodological pitfalls are identified.

Chapter four positions the methodological approach used within the context of social research. The chapter is centred around methods approach adopted for this research, position this within the epistemological and ontological viewpoints of the researcher.

Chapter five outlines the practical application of the quasi-experimental approach taken to address the research aims and objectives. It details the sample selection and recruitment processes and the range of quantitative and qualitative data collection measures used for all stakeholder groups before highlighting ethical principles which were adhered to throughout the course of this research.

Chapter six details quantitative and qualitative findings from the summative and process evaluation methods, including descriptive statistics of all stakeholder groups. The summative findings look at the quantitative outcomes from questionnaires completed at pre post and follow up time points. The process evaluation section looks at data from qualitative interviews with all stakeholders as well as facilitator fieldnotes.

Chapter seven, the discussion, brings together and triangulates the various findings from the process and summative evaluations. It starts by exploring the direct impact outcomes, before going on to discuss key themes and mechanism of impact, providing explanation of the elements that may underpin these quantitative findings. The discussion then leads into how these findings link to the capability of IAP in contributing towards a relationship-centred social care approach and the creation of age friendly communities in care homes. The contributions of the findings for supporting elements of symbolic interactionism are weaved throughout this chapter, especially when exploring the mechanisms of impact and how change has come about. This chapter concludes by highlighting the strengths and limitations of the research, implications for theory, research and practice.

Chapter eight concludes the thesis and brings together the empirical findings for practice implementation, implications and highlighting key conclusions and makes some recommendations.

6.2. Background

In Wales the population is ageing, that is, the proportion of the population comprising older people is increasing (Burholt & Dobbs, 2012). In 2016, one-fifth (20.4%) of the population were aged 65 years or more, by 2033 older people will comprise more than quarter of the population (26%) (Roberts, 2017). Wales has the largest and fastest growing proportion of older people in the UK. Whilst longevity is something to be celebrated, the success will be accompanied by changes in the need for services over the next twenty years. Around 4% of the older population aged 65+ years and 16 % of the population aged 85+ years in England and Wales living in a residential care home (ONS, 2014). In addition to this, 86% of these residents have some cognitive impairment (Burholt et al., 2011) and a high prevalence of loneliness.
Cost pressures for adult social care are projected to rise faster than for the NHS, by an average of 4.1% per year, therefore increasing effectiveness and efficiency is essential for future sustainability.

Research has shown that relocation to a care home can result in long periods of inactivity (Casey, Low, Goodenough, Fletcher, & Brodaty, 2014; Harper Ice, 2002). These changes can which can be compounded by cognitive impairment, can contribute to social isolation and loneliness for older people (Pinquart & Sorensen, 2001), defined respectively as the lack of sustained meaningful connection to other people and the perceived lack of interaction with others (Poscia, Stojanovic, La Milia, Duplaga, Grysztar, Moscato & Magnavita, 2018). The social functioning of people with early or mild stages of dementia is influenced by the way in which they are treated by family and formal caregivers (Sabat & Lee, 2012). The proliferation of national policies focusing on the development of age friendly communities (Ageing Well in Wales, 2019; United Nations, 2020; Welsh Government, 2021) and dementia supportive communities (Lin & Lewis, 2015) acknowledge that inclusion, integration and equity needs to improve. These policies imply that there are barriers to full social participation for people residing in care homes (Burholt, Windle, Morgan, & team, 2016).

Research with frail older adults who had relocated to long term care found different levels of continuity or discontinuity with their ‘old life’ that led to enhanced or reduced quality of life respectively (Tester, Hubbard, Downs, MacDonald, & Murphy, 2004). *Quality of life* (QOL) is defined by the World Health Organization as ‘an individuals' perception of their position in

life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns' (WHO, 2012 p.8). It can be made up of a number of different dimensions, such as physical, social, and psychosocial aspects (Gerritsen, Steverink, Ooms, & Ribbe, 2004).

In addition to the wider care home culture, other factors have been found to influence quality of life of residents in care facilities such as maintaining a sense of self or identity (Moyle, Fetherstonhaugh, Greben, & Beattie (2015), being useful and being able to accomplish something meaningful (Dröes et al., 2006; Moyle et al., 2015); relationships with family and community (Martyr et al., 2018; Banerjee et al., 2006) and activities and therapies (Murphy, Shea, & Cooney, 2007; Tester et al., 2004). Consequently, how individuals spend their time, who they spend it with and the quality of their interactions with others will impact upon ones mood, wellbeing and overall lived experience (Kitwood 1997; Harmer and Orrell 2008; Bradshaw et al. 2012; Edvardsson et al. 2014). Relationships with other people took on an additional importance for residents who had no family, or whose family no longer visited, and in these circumstances staff were expected to fulfil the need for companionships (Moyle et al., 2011).

Research has shown physical activity, music, creative arts, games and reminiscence can increase wellbeing outcomes for residents (Brooker & Duce, 2000; Chung, 2004; Cohen-Mansfield, Marx, Thein, & Dakheel-Ali, 2010; Kerse et al., 2008; McKee et al., 2005; Murray & Crummett, 2010). Presently "only a small number of care homes enable residents to participate in meaningful occupation, activities that are essential to reinforce an individual's identity, such as making tea, baking, gardening, setting the table, keeping pets, taking part in religious services and helping others." (Older People's Commissioner for Wales, 2014). In order to enhance quality of life and counter inactivity, isolation and loneliness, some care homes in Wales provide organised activities (Older Peoples Commissioner for Wales, 2014, p.5). Some innovative care facilities have incorporated coffee shops, meeting rooms, play areas or crèches adjacent to or within the care facility to encourage intergenerational contact and involvement to develop intergenerational relationship between younger people and older adults (Davis, Byers, Nay, & Koch, 2009; Regnier & Denton, 2009).

Over the last decade, there has been an unprecedented number of intergenerational practices emerging which aim to bring young people and older adults together, to tackle multiple and complex policy issues relating to social isolation, ageism and challenges in providing long

term care for older adults. Expected outcomes from such practices have been offered as potential solutions to some of the challenges associated with the delivery of social care. Intergenerational programmes involve social interaction and exchange between older and younger generations. These programmes are assumed to fulfil several purposes, including improved quality of life, physical/cognitive functioning (Park, 2014), wellbeing (Chung, 2009) and personally enriching interactions (Burgman & Mulvaney, 2016) for older people while simultaneously decreasing loneliness or social isolation (Harris & Caporella, 2014). While a substantial proportion of intergenerational activities have been delivered in educational settings (e.g. schools; (de Souza & Grundy, 2007; Morita & Kobayashi, 2013; Murayama et al., 2015; Rebok et al., 2004), they are increasingly being introduced into care home settings (Burgman & Mulvaney, 2016; Sommers, 2019).

Aside from the conceivable benefits for care home residents, there is some evidence that such intergenerational programmes may have the capability to deliver other positive psychosocial and educational outcomes for younger people, such as improved behaviour, self-esteem (Poole & Gooding, 1993) and educational achievement (Marcia, Alicia, Parpura-Gill, & Cohen-Mansfield, 2004; Rebok et al., 2004) alongside a greater empathy, social awareness and better understanding of the older population and ageing (Blais, McCleary, Garcia, & Robitaille, 2017; de Souza & Grundy, 2007; Lokon, Kinney, & Kunkel, 2012; Lynott, Merola, & Ruckert, 2004; Lynott & Merola, 2007). The latter is particularly important, as in the twenty first century the younger population (<16 years) has fewer opportunities to interact with grandparents because of a preponderance of nuclear households; geographic separation between generations (Newman & Smith, 1997); increases in single parenthood, partnership breakdown and re-partnership (e.g. divorce and remarriage) (Walker, Manoogian-O'Dell, McGraw, & White, 2001); and technological changes in communication and entertainment that have dramatically revolutionised social intercourse (Leeson, 2005) and kinship connections in most Western societies (Furstenberg, 2020). As a result, many younger people have limited personal experience of communicating with older people and do not have a point of reference to construct alternative representations to the often-negative media and marketing portrayals of older people. It has been suggested that the lack of familiarity and understanding of older people may compound misconceptions, stereotypes and ageist attitudes, creating a so called '*age apartheid'* (Burke, 2018).

Despite the benefits of contact and familiarity between generations, the UK remains segregated

by age at many different levels; socially, culturally and geographically. This is especially true in supported living environments, such as residential care homes, which decreases the potential for contact between generations (Ellis, 2003). The rise of intergenerational programmes has the potential to change this, with some intergenerational programmes developed specifically to bridge the generation gap (Belgrave, 2011), providing opportunities for both generations to discover how to relate to each other through structured activities and subsequently change negative perceptions of care home environments (Hannon (Canedo-García, García-Sánchez, & Pacheco-Sanz, 2017; Lee, Jarrott, & Juckett, 2020; Radford, Gould, Vecchio, & Fitzgerald, 2018).

Intergenerational programmes in care homes tend to focus on improving the experiences of older people and are often tailored to meet a person-centred approach to care. This approach prioritises the strengths, values and needs of individuals and advocates care practices that foster self-identity, agency and independence(Brown Wilson, Swarbrick, Pilling, & Keady, 2013; Kitwood, 1997), whilst also emphasising the social environment and the relationships between the resident and others (Barbosa, Sousa, Nolan, & Figueiredo, 2015). Although person-centred care models include many positive features, they have been criticised for focusing upon the needs and outcomes for the care home resident and not giving sufficient consideration to the needs and desires of care home workforce and family members (O'Connell, Ostaszkiewicz, Sukkar, & Plymat, 2008).

An alternative approach, relationship-centred care, considers the needs of all stakeholders, and by using this approach, staff are supported to critically reflect upon their practice, to collectively develop solutions and influence action (Brown Wilson et al., 2013). Consequently, a relationship-centred approach to delivering intergenerational programmes in residential care that involves all stakeholders in its development is more likely to be sustainable and demonstrate positive influences on residents, family and staff. Programmes that have a positive impact on staff are particularly important in relation to the current state of social care workforce. A significant amount of work has gone into improving standards of hospital care. However, it is important that future work also focuses on the provision of sufficient high quality social care services that are staffed by well-supported and skilled staff. The social care sector of the workforce looks after 150,000 people and employs 75,000 staff: more than 5% of the Welsh workforce. However, there is a continuing concern over staff turnover (30% in the first two years of employment) and shortfall around 8%) in Wales (Older Peoples Commissioner for

Wales, 2014).

> *"The recruitment and retention of high quality care staff is vital to older people's quality of life. Many of the best care homes are those with high morale among care staff and low staff turnover."* (Older people's commissioner for Wales, 2014)

Care staff can find working with people with dementia emotionally and physically demanding: there are other jobs which are less stressful and pay a similar wage (Alzheimer's Society, 2011). Care managers face challenges motivating and developing teams with the right personal attributes and skills. Relationship-centred care positions the person with dementia within the context of important and significant relationships (Sheard, 2004) and promotes an inclusive vision of dementia care practice. It recognizes that living with dementia is about quality of 'lives' (Mike Nolan, Davies, Brown, Keady, & Nolan, 2004). However, to date, there is scant evidence on the impact of intergenerational programmes on care staff and research studies addressing issues such as staff empowerment (Shavit, 2015) or improved morale (Holmes, 2009) are rare. Programmes that increase workload and have no tangible benefits to staff (even if they improve the quality of life of residents) are more likely to be met with resistance to implementation.

In times of austerity it is hard to ignore the pressures care providers are facing. While intergenerational activities have been suggested as beneficial to older and younger people, little attention has been given to the individuals that are needed to facilitate and co-ordinate such activities, especially those in care settings where workload and pressure is already high. This research will investigate the effect of intergenerational programmes on all stakeholders, these include; younger people, older adult residents and the care staff, with results having the potential to provide impetus to revitalizing approaches to social care staff retention as well as sustainability of intergenerational activity facilitation.

This thesis aims to explore how current intergenerational practice in Wales is meeting these expectations of outcomes and what processes are driving such outcomes amongst participants and facilitators of the activities. The evaluation of these practices to date has often of poor methodological quality, this is something that is discussed later in this chapter.

6.3. Methodological critique of extant literature

Intergenerational research is a multidisciplinary field for example incorporating demography, education, gerontology and psychology. Intergenerational research needs to Focus on the experiences of all stakeholders involved in intergenerational programmes and consider the contexts in which the programmes are delivered in order to better understand best practice. However, many evaluations of intergenerational programmes omit the direct impact such activities have on the so called 'middle generation'. In the context of the care home, the middle generation refers to staff, who are the critical players in the planning and implementation of the intergenerational programmes (Jarrott et al., 2021).

The number of reliable and valid evaluation and research studies is not keeping pace with the development of intergenerational programmes, especially in the UK (Canedo-García et al., 2017). This lag is not seen as surprising, as intergenerational programmes often develop organically, which meant much many evaluations are anecdotal and retrospective. To date, research has failed to disentangle the effects of structured activities on residents in care homes, from the additional (dis)benefits accrued from performing these activities as part of intergenerational exchanges. The majority of studies have been undertaken in North America (Canedo-García et al., 2017; Park, 2015) not all have demonstrated benefits (Biggs & Knox, 2014; Middlecamp & Gross, 2002) and many programme evaluations are of low methodological quality (Knight, Skouteris, Townsend, & Hooley, 2014; Low, Russell, Mcdonald, & Kauffman, 2015). In the current economic climate, with competition for scarce resources, it is necessary for intergenerational programmes to demonstrate whether they infer positive outcomes and benefits.

6.4. Research aims and Objectives

In order to address the identified gaps in research, the purpose of this thesis was to evaluate the effect of intergenerational programmes delivered in care homes in South Wales on outcomes for older residents (including those with cognitive impairment), younger people, and social care staff. It aims to evaluate whether intergenerational activities in care homes can contribute to a more sustainable provision of social care, change attitudes towards ageing and impact on the wellbeing of residents and care staff. The research is built around the overarching research question:

Can intergenerational programmes change, sustain and catalyse cultures, beliefs, attitudes and behaviours to create age friendly care home environments?

The PhD research aimed to address the following sub-questions:

1. Can changes in quality of life of older residents; attitudes of younger people; care workers' job satisfaction; and social engagement between these groups be demonstrated through participation in, or connections with an intergenerational program delivered in a care home?

2. What are the underlying processes of an effective and socially engaged intergenerational programme that improves connections and communication, promotes meaning and enhances well-being?

3. Can the implementation of intergenerational programmes make a central contribution to sustainable relationship-centred social care and the creation of age friendly communities in care homes?

The research will compare the outcomes of intergenerational activities to activities with no intergenerational component, the use of control settings aims to strengthen the methodological rigour of the research. The next chapter aims to set the context in which the concept of intergenerational activities has arose.

2. Chapter Two - Context

This chapter aims to set the scene for the reader. It provides details about the different contexts in which this thesis is aligned to. It explored the wider demographic context, the social and cultural context and political context which have driven the emergence of intergenerational activity programmes as a concept. The fast pace of the modern world in which we live means we are seeing substantial demographic, social and cultural changes. As societies develop, so to do their resource demands and the need for adaptability to keep pace. This chapter provides an overview of the context in which intergenerational programmes operate. It describes the demographic context, along with the social care and policy context. It explores elements of population ageing, increased geographical mobility, changing family structures, generational segregation and ageism within UK societies (McNeil & Hunter, 2014). The final section addresses the theoretical context which underpin the implementation of intergenerational programmes.

2.1. Demographic Context

Much like other high-income countries the United Kingdom is experiencing the effects of population aging. Population ageing can be defined as '*the extent to which a population's age structure is distributed in the older cohorts as a consequence of lower fertility rates and longer life expectancy'* (McPherson, 2004). Addressing the impact of these consequences for older and younger populations is paramount, to ensure a sustainable, prosperous and cohesive future. Consequently, the World Health Organisation (WHO, 2015) has highlighted population ageing as one of the global major public health challenges facing health and social care (Department of Health and Social Care, 2015; Prince, 2015). Demographic changes impact on the population, society and family and are discussed below.

2.1.1. Population structures

A fundamental feature relating to the process of an ageing population concerns changes to the age structure of the population. In the UK and other European countries, a number of factors have exacerbated the disproportionate age structure of an ageing population which is increasingly tipping towards proportionally more older adults. These include a combination of factors; increases in life expectancy, decreases in fertility and decreases in mortality rates, thus increasing the median age of a population (British and Irish Council, 2016).

For decades the UK has seen improvements in life expectancy, and whilst life expectancy is still increasing overall, the latest figures show the rate of improvement has slowed (Office for National Statistics, 2019). In 2019 the population comprised of 66.7 million people, with an increasing proportion of older people and a decreasing proportion of the younger people (Harper, 2006). Figures from the Office for National Statistics suggest that there were 12.4 million people aged 65 and over, this age group is increasing faster than the rest of the other age groups, comprising 18% of the population (Office for National Statistics, 2019). It is expected that there will be an additional 8.6 million older people by 2070, representing a population that is of similar size to that of London in 2019 (Office for National Statistics, 2019). Additionally, the UK totally fertility rate has been declining since 2013, with Wales and England seeing a 3.2% drop-in birth rates since 2017 and a 9.9% decrease since 2012 (Office for National Statistics, 2019). Similar characteristics associated with an ageing population are observed in most high-income countries (United Nations, 2017), therefore altering services and policies to better suit the needs of an ageing population is necessary, to be best equipped to deal with factors associated with ageing populations. This is something that is recognised across the united nations (UN), with the launch of the Decade of Healthy Ageing for 2020 - 2030 (United Nations, 2020), targeting action in the following areas: Age friendly environments, Combatting ageism, Integrated care, and long term care.

2.1.2. Societal and Family Structures

Changes at societal levels in relation to work and greater social mobility also has had knock-on effects on family structures within the UK. Over the last few decades, patterns of family *'formation and dissolution'* have changed considerably (Keating, Kwan, Hillcoat-Nalletamby, & Burholt, 2015). A preponderance of nuclear households, greater geographical mobility and thus separation between generations (Sabater, Graham, & Finney, 2017), as well as changes to relationship stability such as increases in single parenthood, partnership breakdown and re-partnership (e.g. divorce and remarriage) (Letablier & Wall, 2018) has presented the younger population with fewer opportunities to interact with grandparents. Despite more young adults living at home well into their mid-twenties, it is no longer the norm for older relatives to live with their children and grandchildren (ONS, 2019. This coupled with a shift away from altruistic values to more individualistic orientated aspirations in today's society has seen an increase in the number of people and their families relocating for employment and education opportunities (Weber and Sultana, 2007; Phillips, Ajrouch, Hillcoat-Nalletamby, 2010). As a

result, families are more dispersed and subsequently less likely to make face to face contact with family members (Barrie, Bartkowski, & Haverda, 2019) limiting communication and exchange of resources between generation. This is of particular importance when adult children living remotely are less able to provide unpaid care at home to their parents thus increasing the demand and likelihood of individuals seeking alternative care option such as residential or nursing homes (Pickard, 2008). These changes in society have meant many younger people have limited personal experience of communicating with older people within and outside of their family (Lin & Lewis, 2015), limiting the points of reference to construct alternatives representations to the negative media portrayals of older people (Ylänne, 2015). This lack of interaction is compounded by the way in which societies in most European countries are socially segregated across the life course. For example, segregation is apparent within organisations, as well as spatially and culturally (Hagestad & Uhlenberg, 2006).

Organisational segregation is seen when eligibility to be part of the organisation is associated with chronological age. Schools and care settings and common examples of this, with the majority of time spent with individuals of similar age decreasing the potential for contact between generations (Ellis, 2003). Like organisational segregation, spatial segregation can occur when individuals do not occupy the same space. An example of this was mentioned previously with regards to greater geographical mobility within families resulting in less face-to-face interaction with older relatives. Individuals living with dementia in long-term care settings are particularly vulnerable to isolation and segregated from society. Although implicit, this can foster connotations that individuals with dementia live separately and should be avoided.

Many of the social issues faced in the UK are portrayed as generational issues (Keating et al., 2015) such as wealth, labour force and housing. There are claims that these are politically contrived to focus on generational inequalities rather than strengths. As a result policies and societies often fail to see and support diversity or capture different capabilities. For example, the dramatic shift to online resources and services has exacerbated digital exclusion amongst older adults. Despite the rise of older adults as users of technology (Vroman, Arthanat, & Lysack, 2015), digital exclusion can prevent many from full participation in society, especially with the rapidly evolving nature of technology. Research has shown that increasing understanding of technology can enable older adults to be more independent, maintain social networks, and enhance their knowledge of health issues (Karavidas, Lim, & Katsikas, 2005).

Cultural segregation of generations is exacerbated by age-stereotypes. The World Health Organisation defines ageism as '*the stereotyping, prejudice, and discrimination against people on the basis of their age'* (WHO, 2020, para. 1), which has been reported as one of the most commonly experienced forms of prejudice in the UK (Abrams, Swift, Lamont, & Drury, 2015). Media and marketing both draw on and exacerbate the differences between different age groups. For example, there is a raft of anti-ageing beauty marketing campaigns in the media which suggests that visible signs of ageing are to be avoided. Furthermore, negative concepts such as 'demographic time bomb' and 'Millennials' burden' are frequently used to describe the ageing population. Depictions of the ageing population in the media can often influence implicit ageist views and behaviours amongst individuals and create barriers to interaction between individuals, heightening "us versus them" connotations.

In the UK, negative attitudes based on these socially constructed views of age can lead to ageist attitudes and actions. Ageism can not only affect society today but may also influence the future. Societies often fail to provide opportunities for children to interact and develop relationships with persons living with dementia in care, enabling ageist views to persist into adulthood (Holmes, 2009; McNair & Moore, 2010). Cavendish (2016 p44) notes, 'prejudices we build up against the 'old' will only hurt us when we reach that stage ourselves', limiting the ability to positively plan one's own future. This lack of regard for older generations potential to contribute to future generations is echoed by the WHO *'Because older people are often stereotyped as part of the past, they can be overlooked in the surge towards the future.*' (World Health Organization, 2015). Failing to address these negative stereotypes can impact upon policy and decision-making for future government spending and resources to enable healthy ageing. As well as societal impact, negative stereotypes also impact on individuals, with internalisation impacting on life expectancy. In her study Levy found that individuals who viewed ageing more positively lived seven and a half years longer than their peers (Levy, 2009). Longitudinal studies have also found that perceived discrimination can also significantly predict loneliness (Sutin, Stephan, Carretta, & Terracciano, 2015), whilst stereotype internalisation can elicit detrimental physical and mental effects (Levy, 2009). It is important to see and support the differences and similarities between different ages as every age has something to contribute to society.

Social networks, positive contact experiences and education play a pivotal role in the eradication of negative, ageist attitudes (Phillips, Ajrouch, & Hillcoat-Nallétamby, 2010),

especially between generations (Levy, 2018). Intergenerational activity programmes show promise in creating opportunities for intergenerational interactions to occur and relationships with older adults to develop and countering the development and maintenance of negative ageist viewpoints into later life. The potential impact of intergenerational activities on younger people may be particularly useful to the educational sector too. In Wales, the national curriculum changed in 2020. The Donaldson report explains that teaching institutions will be required to provide ways in which young people can be "equipped to cope with new life scenarios" (Welsh Government, 2019) such as an increasing ageing population. All pupils will need to study a range of citizenship themes, and teachers will be given more flexibility to deliver education in more creative ways, which may include intergenerational activities.

2.2. Care Context

There is an increased likelihood of certain chronic conditions in later life (e.g. dementia, arthritis), that mean people are living longer with a disability and high care needs. This, along with greater social mobility and more dispersed family connections are just a few of the factors that may contribute to an increased likelihood of future need for formal care (Prince, 2015; Thein, D'Souza, & Sheehan, 2011). Furthermore, a longitudinal study by Hanratty and colleagues suggests that loneliness could also be a factor that leads to enhanced likelihood of care home admissions (Hanratty, Stow, Collingridge Moore, Valtorta, & Matthews, 2018).

Generally, care homes support older people who require more support than community dwelling individuals. With the average age of care homes residents increasing (ONS, 2014), so too are the complexities and levels of dependency amongst care home populations (Royal College of Nursing, 2010). Approximately 3.5% of the older population aged 65+ years and 16.2% of the population aged 85+ years in England and Wales live in a residential care home (Office for National Statistics, 2011). In 2011, it was estimated that 86% of residents have some form of cognitive impairment (Burholt, Nash, Doheny & Dobbs, 2011), which has considerable implications for the type of care such institutions should be providing (Matthews & Dening, 2002). Unfortunately, such factors are exacerbating the commonly held view of western society that denotes care homes as symbols of the deterioration of health and the striping of an individual's independence, not places where life continues. The regulation and provision of care services in the UK is diverse and multifaceted, with care provided by both public and private organisations. In Wales the care home sector comprise of local authority

care homes (17%), larger group providers; which are often classified as owning four or more care homes (8%), smaller group providers who own either two or three care homes (18%) and single home providers (57%) (Moultrie & Rattle, 2015). The increasing demand and limited resources (Smith & Dray, 2016) within care services, means there is greater pressure on those delivering care to meet the needs of older people.

Care homes are complex environments with an interplay of factors that affect the provision and quality of care provided. While there is evidence to suggest that care homes can create environments in which older adults can receive high-quality care and thrive, there also remains a general sense that more can be done to improve quality of care in the social care sector (Krzeczkowska et al., 2021). Improving the quality of care provided for these individuals is deemed a priority for the UK government. The Quality Matters initiative was launched in 2019, which recognises that providing quality care requires a '*shared commitment for everyone who uses, works in, and supports adult social care'* (Department of Health and Social Care, 2017, p. 3).

Long term care settings are the homes of residents, as well as their main social environment and the place they receive care (Nakrem, Vinsnes, & Seim, 2011). As such, care practices and culture have an important influence on the residents quality of life. Care culture has been defined as '*shared beliefs, values rituals and myths that influence behaviour and decisions*' (Kirkley et al., 2011), it is *'dynamic, locally produced and shifting' (*Killett et al., 2016). The culture created within a care home plays a role in influencing and shaping the behaviour and attitudes of staff and impacts on residents' experiences. Killett et al (2016) identified seven key elements of organisational culture linked to enhancing the quality of life amongst older adults living in care including having a shared goal of providing high quality care, care staff who feel empowered to take responsibility of residents wellbeing, building a sense of community within the care home, residents engagement with meaningful activities, and care staff having a sound understanding and knowledge of residents lives and backgrounds (Killett et al., 2016).

A US study reported that nearly 30% of people with dementia display mild forms behaviours that challenge which can included, mild depression, repetitive behaviours, apathy and shadowing (Lyketsos, Steinberg, Tschanz et al 2000). Research has suggested that behaviours such as these might potentially be reduced by using techniques such as distraction and

reassuring those displaying such BPSD (Brodaty, Draper & Low, 2013). Brodaty et al (2013 p.232) also suggested that they '*may be prevented by altering interactions and the environment*'. Creating a homely environment has also been identified as impacting upon the experiences and quality of life of older adults (Smit, de Lange, Willemse, & Pot, 2012). A physical environment that replicates one's home rather than medical and institutional arrangements, as well as a meaningful daily life style that follows how one would live as if they were in their own home, avoiding regimented and restricted routines (Bradshaw, Playford, & Riazi, 2012). Intergenerational activities offer potential approach which provides home like and natural environment with a mix of generations, offering alternative forms of interactions for older adults in long term care settings, with the younger people acting as distractions.

While increased levels of loneliness may lead to increased chances of care home admission, older adults in residential and nursing homes often remain particularly vulnerable to social isolation and loneliness (Prieto-Flores, Forjaz, Fernandez-Mayoralas, Rojo-Perez, & Martinez-Martin, 2011; Victor, Scambler, & Bond, 2009). Loneliness in care homes may often be overlooked due to the constant presence of care staff and other residents. However, while individuals in care home environments may come into contact with more people on a daily basis compared to an older adult living alone in their home this will only impact on social isolation: when relationships do not meet expectations, loneliness will ensue. Social isolation is defined as the absence or low levels of social contacts, while loneliness is a subjective negative emotion, that is the reaction to a mismatch between the expected or desired number and quality of social relationships compared to those that are actually achieved. A recent review into loneliness amongst older adults in care homes found that rates of loneliness in care homes were greater than levels of anxiety and depression (Elias, 2018). Relationships with others are especially important for residents who have no family or whose family no longer visit (Moyle et al., 2015), and in these circumstances, staff are often expected to fulfil the need for companionship (Goodman, Amador, Elmore, Machen, & Mathie, 2013; Moyle et al., 2015). Intergenerational activities may create a more meaningful environment in which quality social relationships can be formed (Martins et al., 2019).

2.2.1. Meaningful activities in care homes

Although an individual's decision to move into a care home is most commonly determined by health and social care needs, there is increasing awareness and consideration given to value of

the care environment over and above the provision of personal and health care. Participation in meaningful activities is increasingly being recognised by policy makers, practitioners and researchers as essential in ensuring high quality care, and an indicator of quality of life and wellbeing in care homes (NICE, 2013) with policies highlighting the importance of living well with dementia for example (Department of Health, 2009). Activities comprise the basis of everyday life, however in most formal care settings, activities usually refer to staff-led activities run as part of a structured activities programme as the majority of older adults residing in care homes are dependent on support from care staff to engage in activities (Schreiner, Yamamoto, & Shiotani, 2005; Tak, Kedia, Tongumpun, & Hong, 2015). Consequently, many care settings having dedicated individuals or teams (activity co-ordinator or lifestyle and activity teams) responsible for the provision of activities.

The implementation of activity-based interventions aimed at improving the provision of meaningful activities in care settings are relatively common. A review by (Marshall & Hutchinson, 2001) explored the use of activities such as music, art, reminiscence, physical activity, life review, reading and games with people with Alzheimer's disease. A total of 33 studies were reviewed and evidence suggested that structured, meaningful activity promoted social interaction in residential and nursing homes. What makes an activity meaningful to someone is subjective, but broadly, meaningful activities are described as those that '*include physical, social and leisure activities that are tailored to the person's needs and preferences*' (NICE, 2013, p. 11) and include '*activities of daily living, or leisure activities in line with individual preferences*' (Clarke et al., 2019, p. 2).

The opportunity to participate in meaningful activities has been identified as key to enhancing the physical health and emotional wellbeing of older adults residing in care homes (Smit, De Lange, Willemse, Twisk, & Pot, 2016), improving the quality of care and social interaction amongst residents and care staff, less agitation and increased emotional wellbeing (Cohen-Mansfield, Thein, Dakheel-Ali, & Marx, 2010; Day, Carreon, & Stump, 2000), as well enjoyment for staff (Bradshaw et al., 2012; Clarke et al., 2019; Edvardsson, Fetherstonhaugh, McAuliffe, Nay, & Chenco, 2011). Involvement in meaningful activities was also found to be even more profound amongst those with greater levels of cognitive impairment (Smit, De Lange, Willemse, & Pot, 2017).

Therapeutic interventions and activities for people living with dementia such as reminiscence therapy have also been demonstrated to have positive effects, such as reminiscence therapy (Brooker & Duce, 2000) found that compared to unstructured time, group and reminiscence activities enhanced wellbeing. Similar results were also found in a study by McKee et al. (2005), that examined the impact of reminiscence activities on quality of life for residents. They found positive effects on morale and emotional wellbeing using activities with elements of reminisce thus allowing residents opportunities for self- expression and sharing of emotions, which can contribute to building of relationships with those involved (Housden, 2009). This study reinforces the point that to increase quality of life of those living in care settings the provision and choice to engage in meaningful activities and interactions is key. Intergenerational activity programmes may offer an alternative option to providing forms of meaningful activities allowing for a combination of different types of activities, combined with the potential additional benefits of social interaction with individuals from outside of the care setting.

There is however potential for lack of engagement in such activities, for examples individual characteristics such as mood were associated with disengagement. One study found that mood correlated with the ability to attend to activities with more positive mood increasing the amount of time spent engaged with activities (Kolanowski, Bossen, Hill, Guzman-Velez, & Litaker, 2012). A study by Bushell (2018) which used wellbeing profiles and ethnographic observations collected over a period of 6 months found a clear relationship between anticipation in positive and meaningful activities and increased levels of wellbeing. Further to this Bushell found that engagement in meaningful activities simultaneously increased mood and engagement.

Despite the evidence linking physical and mental benefits for older adults to meaningful activity, and steps that regulatory bodies have made to increase activity provision within residential care (NICE, 2015), passive inactivity in care homes settings remains rife (Clarke et al., 2019). The quality and quantity of activities provided in care homes vary substantially. A number of organisational and environmental factors may influence the provision of activities in care homes, such as care home culture and environment, planning, resources, skills and social and community engagement (Harmer & Orrell, 2008; Smit et al., 2016).

Finding appropriate activities that meaningfully engage care home residents can present overburdened care staff with challenges due to the complex needs and characteristics of the residents, and limited time to implement these types of activities. Barriers to delivering

meaningful activities may stem from the care home environment and insufficient space (Clarke et al., 2019); Harmer and Orrell (2008) capacity of care staff (Smit et al., 2017) (Kuhn, Fulton, & Edelman, 2004; Smit et al., 2017) and time pressures (Clarke et al., 2019). In addition to this, a lack of engagement in activities is also influenced by a number of different factors such as lack of interest or poorly selected activities. Conversely, research looking at specific factors that enhance or positively influence residents engagement with activities demonstrated that delivering activities in smaller groups as opposed to larger central activities was more beneficial (Train, Nurock, Manela, Kitchen, & Livingston, 2005).

The benefits of the provision of meaningful activities extend to the staff delivering it by promoting feelings of enjoyment, job satisfaction, and enhancing staff morale. For example, even one-to-one interactions such as walking outside of the care home, brought a sense of enjoyment and reward to staff, seeing the difference it made to the resident (Clarke et al., 2019). Another study demonstrated that it was '*the little things'* that were shown to be of importance to family members of residents in relation to their perceptions of care quality (Ryan & McKenna, 2015). Thus, meaningful activities can be simple tasks or interactions but that are salient to particular individuals: this does not always involve highly structured, routine activities. However, care staff have noted concern that talking, listening and sharing is not recognised as *'real work'* amongst care organisations (McKee et al., 2005).

It is evident that engagement in meaningful activities is beneficial for care home residents, with relationships and social interactions at the heart of most meaningful activities. IAP offer potential in bringing a range of new people and opportunities to carry out activities with others, allowing older adults to attribute greater meaning to otherwise routine activities. However, it is also clear that there are a number of factors to consider when implementing activities and the processes that are required in order to deliver them successfully and in a way that is meaningful for everyone.

2.2.2. The importance of relationships in care environments

The social care sector of the workforce looks after 150,000 people and employs 75,000 staff: more than 5% of the Welsh workforce. However, there is a concern over staff turnover (30% in the first two years of employment) and retention in Wales and a shortfall in social care staff (around 8%) (Older Peoples Commissioner for Wales, 2014). Care managers face challenges

maintaining, motivating and developing teams with the right attributes and skills. This is important, particularly given the challenging nature of the work that care staff workforce are faced with when providing care for people with dementia compared to other jobs deemed to be less stressful and paying similar wage (Alzheimers Society, 2011).

Three approaches to the delivery of care have been identified; (i) individualised task-centred, (ii) residents-centred (or person-centred) and (iii) relationship-centred (Brown-Wilson and Davies (2009). Each approach has a subsequent knock on effect on the relationships care staff develop with residents. Person-centred care prioritises the strengths, values and needs of individuals and advocates care practices that foster self-identity, agency and independence (Brown Wilson et al., 2013; Kitwood, 1997). It emphasises the social environment and the relationships between the resident and others (Barbosa et al., 2015). While person-centred care models include many positive features, they have been criticised for focusing upon the needs and outcomes for the care home resident and not giving sufficient consideration to the needs and desires of care home workforce and family members (Hutchinson et al., 2017). An alternative approach, relationship-centred care, considers the needs these stakeholders too (Brown Wilson et al., 2013; Ryan, Nolan, Reid, & Enderby, 2008).

Relationship centred care emphasises the care home as a community where older people, staff, family and friends are equally valued (Nolan, Brown, Davies, Nolan, & Keady, 2006). Relationship-centred care places the person with dementia within the context of important and significant relationships' (Sheard, 2004) and promotes an inclusive vision of dementia care practice (Nolan et al., 2004). Nolan et al. (2006) described 'six senses' required to create an enriched environment of care. These include a sense of security, sense of significance, sense of continuity, sense of belonging, sense of purpose, and sense of achievement. He argued that in order to deliver relationship-centred care, each of these senses should be experienced by older people, care staff and their families. Similarly, Robinson et al. (2010), found that relationships were central to making residents feel at home. The authors concluded that care homes must encompass a relational orientation *'both philosophically and in practice'* (Robinson, Reid, & Cooke, 2010, p.2). Nursing home residents have suggested that the relationships they had with staff and the communication that was used between them was a significant predictor of the residents quality of life (Grau, Chandler, & Saunders, 1995). Furthermore, Brodaty, Draper, and Low (2003) suggest that care staff that invested time in establishing interpersonal relationships with residents reported greater levels of job satisfaction

and reduced rates of staff turnover. However, care staff do not always fully recognise the importance of developing quality relationships especially when time and resources are stretched (Clarke et al., 2019).

Intergenerational programmes in care homes tend to focus on improving the experiences of older people and are often tailored to meet a person-centred approach to care. An alternative approach – relationship-centred care – considers the needs of all of these stakeholders (Brown et al 2013; Ryan, Nolan, Reid & Enderby, 2008). Using this approach, staff are supported to critically reflect upon their practice, to collectively develop solutions and influence action. Consequently, a relationship-centred approach to delivering intergenerational programmes in residential care that involves all stakeholders in its development (Goyer, 1998; Jarrott, Gigliotti, & Smock, 2006) and demonstrates positive influences on residents, and staff is more likely to be sustainable. It could contribute to a more enriched care environment and potentially the greater retention or attraction of care staff to long term care settings. However, intergenerational programmes may also overburden care staff with requirements outside of their job description, with intergenerational activities potentially increasing their already heavy workload.

2.3. Policy Context

Population ageing has important consequences globally and as a result addressing and managing these has taken precedence for many policy makers in developed countries. The United Nations highlighted the need for forward thinking policies, and the need to '*identify the essential characteristics of intergenerational contact interventions and the right mix of intergenerational and educational components in combined interventions* (United Nations, 2021, p.134). The following section provides a brief timeline of the origins and development of intergenerational practice which are intertwined with key policies from countries on both national and international levels. An overview provided in Table 1

Research is crucial to shaping policies and informing practice. Policies set out to guide actions in order to achieve an end goal, and are constantly adapting and changing in response to changing circumstances, and in line with current research. The interconnected nature of policy, research, practice and theory has been highlighted, especially within the intergenerational field (Bernard, 2006; Sánchez et al., 2007). Whilst there is contention as to what takes precedence,

research (Bernard, 2006) or practice (Sánchez et al., 2007), it is clear that policies are influenced by both aiding the translation of informal practice into standard practice via policy recommendations, should the research demonstrate plausible benefits to the public.

Table 1

Key milestones in the history of intergenerational programmes (IP)

Decade	Milestones of Intergenerational Programme
1960s	• Earliest non-familial intergenerational interventions in the United States (i.e., Foster Grandparents in 1965). Demonstrating a range of personal and academic gains
1970s	• The systematic development of intergenerational programmes led to the appearance of new programmes organised by both local and State governments and foundations in the United States.
1980s	• The first Intergenerational charity, Generations United was Established in the US. • Generations Together, an intergenerational centre linked to the University of Pittsburgh, organised the first Intergenerational Certificate, providing professional accreditation within this new field. • North American universities introduced intergenerational learning into their syllabus, providing practical training opportunities to become involved in intergenerational projects. • The publication of manuals explaining how IPs are organised helped to create sustainable long-term programmes
1990s	• The European Year of Older People and Solidarity between Generations in 1993 • Publications produced in the mid-1990s (Maureen O'Connor 1993, David Hobman 1993, Volunteer Development Scotland 1997, Chris Jones 1996) raised the profile of intergenerational work in the UK, tracing its development and raising a number of important issues. • Creation of the International Consortium for Intergenerational Programmes (1999) • The UK programme for the United Nation's International Year of Older Persons had 'Generations Together' as one of its four themes. (1999) • International Consortium for Intergenerational Programmes (ICIP) (Netherlands) (1999)
2000s	• Signing of Article 14 at the Second World Assembly on Ageing in Madrid (2002) • Creation of the Beth Johnson Foundation's Centre for Intergenerational Practice, in the United Kingdom (2001)

	• Launch of the Journal of Intergenerational Relationships (JIR), a journal created to promote communication in the intergenerational field. • Cymru Centre for Intergenerational Practice funded by WAG (2004-2007) • Launch of the Japan Intergenerational Unity Network (2006) • Specific Intergenerational Programme training courses are formed at The universities of Pittsburgh (United States), and University of Lampeter (Wales) (2007). • Welsh Government publishes the Strategy for Older People in Wales (2008-2013) • Launch 'Generations Together' demonstrator projects of intergenerational practice across 12 local authorities in England (2009). • Launch of 'Linking Generations, Northern Ireland' (2009) • Welsh Government launches framework to support intergenerational practice for local authorities (2009)
2010s	• 'Generations working together' became a registered Scottish charity, with 6 members of staff and 40 volunteers (2015). • Hen Blant Bach series and research (2016/17) • Creation of "Generations working together" centre for excellence funded by Scottish Government (2017) • Toddlers who took on Dementia (2018) • 'Ffrind i mi' Intergenerational strategy is published by Aneurin Bevan Health Board (2018) • Intergenerational Housing Network formed (UK) (2019)
2020s	• Launch of National Intergenerational Week (St.Monicas Trust, UK) (2020) • Welsh Government 'Connected Communities' strategy published to combat loneliness & social isolation (Intergenerational strategies are suggested under Priority 4) (2020) • Welsh Government publishes new Schools Curriculum with a focus on community (Donaldson Report) (2020) • Cross-party parliamentary group formed on 'Intergenerational Solidarity' – inaugural meeting held in November (2020) • Launch of the Global Campaign to combat ageism and the global report on ageism (2021) • Launch of the 'Age friendly Wales: our strategy for an ageing society' by Welsh Government (2021), with direct mention of encouraging intergenerational contact. • United nations Decade of Healthy Ageing.

2.3.1. International Policy Context

The year of 1993 was promoted as the European Year of Solidarity between Generations. This stemmed from growing concerns over population ageing across Europe and the need to rethink societal structures in order to ensure a more sustainable future. This acted as a catalyst for a range of intergenerational proposals which captured the attention of a wider audience to the value of more intergenerational approaches and communities. The start of the millennium saw the promotion of intergenerational activities on an international scale with the publication of the United Nations Madrid International Plan of Action on Ageing (2002). In light of this and the publication of policies relating to social inclusion and community cohesion within the UK the early 2000's saw the development of intergenerational centres. The Beth Johnson Foundation, based in Stoke on Trent, was funded by the National Lottery in 2003. In England, the centre for intergenerational practice was established to develop intergenerational work across the UK. The centre provided support to practitioners and policymakers to promote the relevance of IG practice. In Scotland, the university of Strathclyde established the Scottish Intergenerational Network. Following national consultation in 2007, the Scottish government published their strategy for and ageing population 'All our Futures'. The Scottish Centre for Intergenerational Practice at Strathclyde University in partnership with the Beth Johnson Foundation changed its name to 'Generations Working Together' and developed an online intergenerational learning course ICIL in partnership with the university of Grenada, Spain.

The WHO created the 'Age Friendly' concept in order to support health ageing, resulting in the development of an age friendly framework in 2007 (World Health Organisation, 2007). This covered eight domains that were felt to influence the health and wellbeing of older adults. These include; outdoor spaces and buildings; transportation; housing; social participation; respect and social inclusion; civic participation and employment; communication and information; and community support and health services. A resurgence in practice and renewed interest from the media promoted intergenerational practices in a positive light, especially within social care. This reignited interest and growth of intergenerational programmes once more. This also coincided with the European Year of Active Aging and Intergenerational Solidarity in 2012. More recently, national legislation actively supports activity which encourages mutual trust and reciprocity between the generations and serves to tackle ageism and age discrimination.

In 2013 the launch of the Dublin Declaration on Age-Friendly Cities and Communities, meant that cities and communities having to demonstrate implementation, change and evaluation to be recognised as age friendly. There has been substantial interest in the concept (Emlet & Moceri, 2012; Lui, Everingham, Warburton, Cuthill, & Bartlett, 2009), with over1000 cities in 41 countries have now committed to becoming age friendly cities that support those of all ages to 'age actively', in particular older adults, (World Health Organisation, 2007, p. 5), by adopting an age friendly lens through which policies and services are understood, planned, evaluated and implemented (World Health Organisation, 2018). Many talk about age friendly communities in relation to the community dwelling older adult population, often overlooking the most vulnerable older adults living in care environments (Shaw, 2018). An international literature review of age friendly communities, identified that an engaging social environment was just as important for wellbeing of older adults as the physical environment (Lui et al., 2009), with later research further supporting the importance of social inclusion and engagement as key factors in creating age friendly communities (Emlet & Moceri, 2012; Mitchell et al., 2003). However, it seems that despite the surge of interest in this concept a concrete indicators which are valid and inherent to different contexts across the country are still in its infancy (Steels, 2015). In order to identify strengths and weakness of age friendly interventions that are implemented, it had been reiterated that such they should be 'subject to rigorous evaluation' (Steels, 2015:p13).

An All-Party Parliamentary Group (APPG) dedicated to social integration was set up in 2016 to break down the barriers of integration. In 2019 they published a report titled '*Healing the generational divide'* which identified four key policy areas in relation to intergenerational connections: community projects and initiatives, public service, housing and planning and technology. This report details the foundations of a framework which prompts local, regional, and national government to work in partnership, with the aim of enhancing cross-generation connections. A call for evidence on the effectiveness of intergenerational programmes received a positive response but received only five academically rigorous pieces of evidence. Key take-home messages from this report include the recommendation to focus on 'rebuilding intergenerational bonds', with the recognition that government resources, leadership and policy need to reflect this drive, while identifying that community development initiatives should be led locally. Despite limited evidence, in their public health guidelines on independence and wellbeing, NICE deemed that on balance, intergenerational interventions were beneficial and recommended intergenerational activities as examples of good practice for working with older

adults, in their public health guidelines on independence and wellbeing in older people (NICE, 2015). Furthermore, in a report on integration and cohesion, the Department for Communities and Local Government (DCLG) suggested that intergenerational programmes could be key in achieving community cohesion (Commission on Integration and Cohesion, 2007). The NICE and DCLG reports however were mainly targeted at and related to community dwelling older adults and gave very broad examples of what intergenerational activities comprised *'Older people helping with reading in schools or young people providing older people with support to use new technologies'* (NICE, 2015, p. 7)

The proliferation of national policies focusing on the development age friendly communities (McGarry, 2018) acknowledge that inclusion, integration and equity of older adults especially those in care homes needs to improve. These policies imply that there are barriers to full social participation for people with cognitive impairment (Burholt et al., 2016). The social functioning of people with early or mild stages of dementia is influenced by the way in which they are treated by family and formal caregivers (Sabat & Lee, 2012). However, there is little research that explores stigma, prejudice, discrimination and stereotypes associated with cognitive impairment amongst the workforce (Harrison, 2014) and how this may impact on the quality of the care provided and residents quality of life. Attitudinal change via enhanced intergenerational contact in care homes and enabling different social environments for older adults in care homes may offer a way of improving attitudes towards people living with dementia amongst the social care workforce.

Our physical and social environment provide us access to vital resources to thrive. The United Nations (UN) has dedicated the decade of 2020 to 2030 as a decade of concerted global action on healthy ageing, with older people at its core (United Nations, 2020). It puts a spot light on the need to examine the extent to which communities are good places to grow old; and whether communities have sufficient resources to act and be supportive to it's older residents. To do this, the UN promotes key areas that need further attention from researchers, policy makers, societ and international agencies. These are; Age friendly environments, combatting ageism, integrated care and long term car. Keating (2022) suggested that researcher priorities should and can be informed by regional and national strategies that reflect these decade actions.

2.3.2. Welsh policy context

The publication of the Strategy for Older People in Wales in 2003, kick started the development and promotion of intergenerational practice across Wales. The Beth Johnson Foundation was commissioned to develop a specific Intergenerational Strategy for Wales, forming a partnership with the University of Glamorgan and establishing the Cymru Centre for Intergenerational practice (CCIP) (Beth Johnson Foundation, 2008). The University of Lampeter was the first university in the world to launch the European Certificate in Intergenerational Learning (ECIL). However, due to lack of funding the Centre's work has since ceased and there was a notable lack of international activity in Wales up until the late 2010s.

In line with Wales being recognised as an Age-Friendly Nation, all 22 of Wales's Local Authorities have signed up to the Dublin Declaration (Ageing Well in Wales, 2019). The age friendly concept remains slightly out of sync with care homes. The transition into care homes should not mean individuals have to withdraw their engagement or connection with their community, although this is often the case. A care home is home for the residents living within it; it is a micro community in itself. Care environments should be striving to encourage and enable their residents to continue to engage with their surroundings and encourage social interaction with people in their communities, in order to maintain individuals health, independence and wellbeing. This ties in with dementia supportive communities, which are defined by ageing well in Wales as 'Any community that shows a high level of public awareness and understanding of dementia' (Ageing Well in Wales, 2019) with them suggesting that in order to create such communities a social movement is needed to have the capacity to support people affected by dementia. Some of the mechanisms include; challenging stigma and building dementia awareness, ensuring that activities include people with dementia, empowering people with dementia and recognising their contribution to society, and supporting them to engage with community life. These encompass some of the values driving intergenerational practice. These aims are also reflected in the recent 'Age friendly Wales: our strategy for an ageing society' (Welsh Government 2021), strategy by Welsh government which actions to reap the benefits of growing number of older people in Wales and enhancing peoples wellbeing. One way the strategy sets out to do this is by encouraging the growth and embedding of intergenerational contact. The strategy also touches upon the use of

intergenerational activities as a way of promoting the transmission of Welsh language through the generations (Welsh Government, 2021).

The Welsh Government has continued to develop policies which reference to intergenerational practice. Published in 2011, the white paper titled Sustainable Social Services for Wales: A Framework for Action, highlighted a number of challenges faced by public services in Wales. Its aims were to address issues associated with the delivery and promotion of high quality and consistent social services. Subsequently a number of related policies have drawn upon co-production with Public Service Boards, embodying a long term sustainability perspective and approach to services. A review conducted by the Older People's Commissioner in 2014 which looked at the care home context in particular, provided the use of befriending schemes as a key recommendation. This drew attention to the importance of a relationship-centred approach to care and highlighted how under-supported and unacknowledged the workforce of care homes are (Older Peoples Commissioner for Wales, 2014).

As life expectancy increases, policies for health and social care are embracing an outward future perspective, with aims of improving wellbeing and reducing isolation across all ages. The Welsh Government introduced a wave of new legalisation, through the Social Services and Wellbeing (Wales) Act in 2014, followed by the Well-being of Future Generations act in 2015 (National Assembly for Wales, 2015). These were significant and their aim was to encourage service providers to consider factors which might affect the wellbeing of present and future generations, enhancing co-production and ensuring a '*holistic and long-term response to loneliness and isolation in Wales* (Welsh Government, 2018: p1). For example, the Well-being of Future Generations (Wales) Act suggests that intergenerational activities could help to create *'a Wales of cohesive communities'* and prompts public bodies to make '*simple chang*e' by exploring opportunities for intergenerational practice and creating conditions in which in old and young can interact (Wellbeing of Future Generations Act, 2015)

In 2017, the Health, Social Care and Sport Committee launched an enquiry into loneliness and isolation, which resulted in six key recommendations (National Assembly for Wales, 2017). Recommendation five, called for the Welsh Government to undertake evaluation of research into the impact of intergenerational contact on those that are isolated and lonely, and if beneficial, to roll-out best practice (National Assembly for Wales, 2017, p. 6). The Welsh Government accepted this recommendation (Welsh Government, 2018), recognising the

potential contribution intergenerational practice could have in building stronger communities and addressing isolation and loneliness.

Between October 2018 and January 2019, the Welsh government undertook a Consultation that focused on how best to tackle loneliness and social isolation in Wales. The consultation document asked 23 questions on a range of key subjects and issues which were identified as being relevant to tackling loneliness and social isolation. This process was intended to gain views from a range of stakeholders in order to help inform the development of a cross-government strategy. A total of 234 responses were received from across different organisations and from members of the public. Top priorities included providing space to encourage mixing between the generations as a way to support young people to maintain social connections, with care homes cited as an ideal space to promote and facilitate more community activity.

Shortly after this, the Welsh government commissioned a review of key mechanisms involved in intergenerational practices, and their effectiveness at reducing loneliness/social isolation, through the selective review of case studies, phone interviews with identified key stakeholders (Bryer & Owens, 2019). The review highlights key elements which would contribute towards sustainability of practices and provides eight recommendations for the Welsh Government to consider in terms of future policy relating to intergenerational practice. This included creating a national driving force to initiate, coordinate and support the range of good practices happening across Wales. It should be noted that all case studies were selected on the basis that the outcomes included loneliness and social isolation, by virtue excluding practices with other aims and with unintended consequences. The reviewers found that very few publications included the remit of evidencing the impact on loneliness and social isolation. Thus, the scope and inclusion of case study sites in Wales is limited.

The role of the media in promoting the development of intergenerational practices can also be seen in Wales and the UK, with the likes of the Channel 4 documentary series ‘Care Homes for four year olds’ which initiated a significant amount of attention from media outlets, and the S4C document ‘Hen Blant Bach’ in 2018 a three part documentary which followed interactions between two generations, as nursery children visit a centre for the older adults.

On the local level various intergenerational initiatives have been in development. For example, in Aneurin Bevan Health Board 'Ffrind I Mi' was developed with the aim of tackling loneliness and isolation within the community. It has facilitated intergenerational practice in South Wales and an intergenerational strategy and tool kit has been produced as a result to help provide guidance for the development of intergenerational practice across South Wales (Ffrind i Mi, 2018).

Aside from social care policies, intergenerational practice has relevance to other sectors. The Donaldson Report, an independent review of curriculum and assessment arrangements in Wales, highlighted the need to change the curriculum in order to ensure younger people have *'the opportunities to learn from expertise and experience from outside the school environment'* (Donaldson, 2015, p. 71). The report suggests that the new curriculum should help younger people become; ethically informed citizens, ambitious capable learners, enterprising, creative contributors and healthy confident individuals. Further to this, teaching institutions will be required to provide ways in which young people can be 'equipped to cope with new life scenarios' such as an ageing population (Welsh Government, 2019). All pupils will be required to study a range of citizenship themes and teachers will be given more flexibility to deliver education in more creative ways, which may include intergenerational activities.

Whilst the new curriculum has been welcomed, the Education Committee have raised a concern over the lack of mechanisms in place that enable implementation of the review into practice by 2020 (National Assembly for Wales, 2017). Intergenerational practice could help by providing children and young people with opportunities to learn from the expertise and experience of older people outside the school environment. Such activities could enable the social and emotional development of younger people.

In 2021, the Welsh Government launched an age friendly strategy for Wales (Welsh Government, 2021). In 2021-22, £550k was made available to support this work. In 2022-23, funding of around £1.1million is available, with £50k for each local authority. One of the goals of the strategy that the government set out to achieve was building and retaining people's own capability. One way they have outlined they will achieve this is by working closely with the implementation of the Strategy for Loneliness and Isolation. They aim to encourage 'all local health boards and local authorities across Wales to establish, embed and grow intergenerational practice' (Welsh Government, 2021, p15). It aims to take a multi-agency approach to mapping

intergenerational activity and explore the sharing and replication of good practice, with Older People's and Children's Commissioner for Wales, local authorities and older people's groups and forums working together to do this. The strategy also highlights the importance of using intergenerational work to help younger people gain of improve their Welsh language skills.

While policies are increasingly recommending the implementation of intergenerational practice, recommendations are often surface level recommendations that fail to extend in to committed funding or support to facilitate such practices. Advocates of intergenerational practices still face significant challenges incorporating intergenerational programmes into care practices in Wales and other areas of the UK. This is in part due to the lack of substantial and high-quality evidence base relating to intergenerational programmes running in the UK, which means it is difficult to persuade funders of their effectiveness and utility. In addition to a lack of funding, another problem relating to implementing policy recommendations on intergenerational practice is the lack of clarity concerning content, mechanism of delivery and intended outcomes. As a result, recommendations are often too generic, thus reducing the likelihood of embedding these into practice. Policy recommendations often generate a surge in the number of planned intergenerational activity programmes, however the absence of a systematic framework to help guide implementation consistency and integrity is likely to vary. Although a Welsh IG strategy was published in 2012 this failed to translate this into practice, and currently there is no active intergenerational policy in place in Wales. This research aims to provide robust and reliable evidence to reinforce this and identify recommendations to support the translation of intergenerational programmes into care homes into best practice across Wales and further afield.

The concept of intergenerational practices is usually tied up with a wider policy agenda e.g. social inclusion, solidarity, age-friendly communities (more recently, to social isolation and loneliness & building stronger social connections, Building Awareness and Promoting Positive Attitudes), solidarity and cooperation and rarely as a stand-alone concept. Suggesting the development of the concept has political element to it agenda. The development of IG practices were very much founded in grass-roots, this has since evolved in line with the socio-political context, potentially as a function of the power relations in local and national government. The scale of developments in practice are harder to track, though can be inferred from reports e.g. from UK Think Tank, and from organisations such as Linking Generations Northern Ireland (NI) and Generations Working Together (Scotland) which all point to quite a rapid increase in

projects/initiatives over the last decade. There seems to be a gap for the equivalent organisations based in Wales.

2.4. Theoretical context

Intergenerational practice is making great strides, with considerable increase in the number of manuals and 'models' of best practice that are produced. There is an increasing use of theory amongst more recent research (Jarrott, 2011; Kuehne & Melville, 2014). However, intergenerational theory and an underpinning conceptual framework remains fragmented across different disciplines. The development of a unifying intergenerational theory is still in its infancy (Epstein & Boisvert, 2006; Kuehne, 2003; Vanderven, 2011). There is a need for concrete theoretical groundings from which understanding, and implementation of intergenerational programmes can evolve and inform policy makers.

One of the strengths of intergenerational programmes is the integration of knowledge from a variety of relevant fields, such as, gerontology, psychology, sociology, the arts and education (Martins et al., 2019). The most prominent fields developing theory and knowledge about intergenerational interventions are gerontology, health sciences and education studies (Canedo-García et al., 2017). Disciplinary diversity is also reflected in the theories utilised by researchers (Kuehne & Melville, 2014).

Typically, the theoretical foundations of intergenerational research have been influenced by the main discipline in which it has been implemented. The focus can vary in terms of the participant groups involved, the outcomes under consideration, the research settings and the type of research method being conducted. Consequently, a variety of theoretical underpinnings have been used to guide, interpret and support intergenerational research and programmes (Jarrott, 2011). The next section uses the classification system proposed by Kuehne and Melville (2014) to help identify and contextualise some of the most prominent theoretical groundings within intergenerational work to date. Their work helps categorises theories into two main groups; (i) theories focusing on individual development specifically and (ii) theories focusing on people and groups within an interactive context.

Individual action and developmental Theories

Developmental theories - Early intergenerational programmes took a human developmental perspective to validate the significance of the work (Kuehne, 2003a; Jarrott, 2011; Kuehne & Melville, 2014), reasoning that both older and younger individuals share a number of developmental needs that can be fulfilled both psychosocially and educationally (Kuehne & Kaplan, 2001). For example, the need to be nurtured, taught and have positive role models pertain to younger developmental needs, whilst the need to teach, have purpose, and to feel valued are traits attributed to adult developmental theories (Hatton-Yeo et al., 2000).

According to Erik Erikson's theory of psychosocial development (1963), a common reference for intergenerational studies, older adults strive to find a way to contribute to society that will benefit future generations shifting focus of one's own life to that of others. This is known as 'generativity' stage of development and has been referred to as a '*positive response to later life'* (Warburton, 2014). It has been suggested that intergenerational programmes facilitate the exchange of knowledge and experiences to younger generations, fulfilling older adults generativity goals (Belgrave, 2011). This can be beneficial for both the older adults and society as a whole (Pratt, 2013).

The developmental stage of identity formation is highlighted as another area that intergenerational exchanges can help develop. At this stage individuals are developing a sense of personal meaning and direction; in order to form an identity, they strive for knowledge about themselves and the world. Older adults in IG programmes serve as positive role models imparting wisdom and guidance to youth (Kessler & Staudinger, 2007).

Most intergenerational research drawing on Erikson's stages of development omit reference to the last stage, 'old-old' age which is probably the most relevant age range (age 75+) for older adults in care home. The age of 'generativity' as described by Eriksen (1963) seems best suited to those who actually organize and implement intergenerational programmes, such as activity coordinators and teachers. However, the direct impact that intergenerational activities have on these individuals is often overlooked. Graves & Larkin (2006) have explored the role of intergenerational programmes, on 'autonomy' as a developmental stage. They suggest that intergenerational programmes provide an ideal environment to support the development of autonomy for both younger and older participants. Although Erikson's developmental theory

has been used to demonstrate reasons why intergenerational programmes may be beneficial to younger and older people it has been argued that it is reductionist in its approach to understanding intergroup relations (Kuehne & Melville, 2014). This is reflected in the focus on attitudinal changed as a main outcome. Furthermore, the categorisation of individuals to stages in life based on their chronological age could be argued as too deterministic and assumptive in terms of assigning adults particular desires in later life (e.g. in stage seven; generativity vs stagnation). Developmental theory fails to consider the wider social influences and outcome, offering little explanation about how practice works to promote social change.

Interactive group theories

In a recent review of the intergenerational literature, Martins and colleagues (2019) showed that the most commonly utilised theory was contact theory (Chase, 2010; Hatton-Yeo & Ohsako, 2000; Hewson, Danbrook, & Sieppert, 2015; Jarrott & McCann, 2013; St John, 2009; Weaver, Naar, & Jarrott, 2017; Whiteland, 2016). Contact theory is a social psychological theory. It was originally introduced by Allport (1954) to explain racial prejudice. Allport posits that social contact between different social groups can reduce prejudice as long as four key conditions are met. These are, equal status between groups, co-operation, working towards a common goal and institutional authorities support.

Building on Allport's contact theory, the intergroup contact theory (Petigrew, 1998) suggests that prejudice can be reduced through four key interrelated processes; (i) learning about the outgroup, (ii) behavioural change, (iii) relationship forming, and (iv) the influence of individual differences and societal norms in shaping the effects of intergroup contact. As many of these conditions and processes mirror those occurring within intergenerational programmes researchers have applied intergroup contact theory to intergenerational settings (Pettigrew 1998; Gigliotti, Morris, Smock, Jarrott and Graham, 2005; Jarrott and Smith, 2010). Subsequently, Fox and Giles (1993) constructed the intergenerational contact model.

The intergenerational contact model builds on the concept that intergenerational exchanges are 'intergroup' and 'intercultural' (e.g., Giles & Coupland, 1992; Hewstone & Brown, 1986), with persons from (at least) two cultural age groups communicating with one another in programme settings. Specifically, this is a communication theory that focuses on how people of various ages develop attitudes toward and communicate with those in other age groups. Several variables are considered important in this theory and are borrowed from cross-cultural contact

frameworks (Bochner, 1982). Variables include frequency of contact, level of participant intimacy, relative status of participants, and duration of the intergenerational contact. However, intergenerational relationships are not just about duration of contact and profile of participants, they are about place and relationships (Stafford, 2006). Humans are innately social animals, and environmental psychology (Manzo and Perkins, 2006) suggest that the places in which people live and work affect their identities, values, behaviour, and relationships with others (Manzo and Perkins, 2006). This may be especially important in care homes for staff, residents and younger people. Similarly there is increasing recognition on the potential impact intergenerational activity programme may have on the facilitators and care staff involved. Whereas IAP was predominantly about bringing old and young together there is increasing interest in encouraging all stakeholders to make an active contribution (Biggs and Lowenstein, 2011).

One theory that draws on the importance of meaning, as well as taking into account environmental and societal influences is symbolic interactionism. The social nature of human beings lies at the heart of this theoretical perspective, viewing the individual and society as inextricably connected in terms of interaction and understanding. The meaning an individual ascribe to an object or another person influences behaviour and subsequent interactions. Symbolic interactionism has been used as a framework in the social care field (Burbank and Martins, 2009) and recently within intergenerational practice (Skropeta et al 2014; Wright-Bevans, 2017). This theory combines individual developmental theory with social constructionism: its focus on language, symbols and meaning come from social cultural influences and environmental cues.

Whilst such theoretical foundations may provide some explanation for certain outcomes such as contact theory for attitudinal change. Symbolic interactionism (SI) is one of the few sociological models within the intergenerational literature which attempts to understand how social change occurs as opposed to focusing just on the impact outcomes of such change.
SI is based on three key tenets; 1. Individuals respond to things based on the meaning they have associated to them, 2. These associated meanings arise from social interactions individuals have with others, and 3. The associated meaning is dynamic and can be changed or altered depending on individual experiences and encounters with people and things. Culture also affects interactions and the assessment of situations. SI suggests that an individual's expectations and benefits derive their meanings from the individuals definitions of the situation

and past experiences (Blumer 1969). This dynamic nature of interactions is something that is reflected in the ability of intergenerational programmes to potentially alter attitudes for participants. As a result the theory could be used to explain participants views and mechanisms of change through a range of different interactions and new social roles within the context of IAP. One other study has also drawn upon symbolic interactionism to explore the impact of intergenerational activities on older adults with dementia (Skropeta et al, 2014).

2.5. Chapter summary

Much of the rationale for the development of intergenerational practice and activities has arisen from the demographic and societal changes outlined in this chapter (Bernard & Ellis, 2004). Research from this contextual chapter suggests that there is potential for intergenerational activities in care homes to enhance social care provision, creating opportunities for meaningful activity that encourage social interaction. Harnessing the philosophy of relationship centred care. which views care homes as communities where older people, younger people and care staff are valued (Smith & Dray, 2016). Within the Welsh context, recommendations for use of IP are weak, and do not describe well the mechanism of change. This thesis recognizes the complexity of care home environments, the provision of care and the subjective nature of the individuals they support. For these reasons, symbolic interactionism will be used as the underpinning theory to guide the interpretation of the data. This research aims to provide evidence as to whether intergenerational programmes can change, sustain and catalyse cultures, beliefs, attitudes and behaviours to create age friendly care home environments. The next chapter will examine the evidence for the effectiveness of intergenerational practice and programmes in more detail.

3. Chapter Three - Understanding intergenerational practice

The previous chapter outlined the background relevance and purpose of the study. This chapter aims to explore the literature on intergenerational activities, and specifically intergenerational activity programmes run in care homes and the potential outcomes for various stakeholders (Pickard, 2015). The chapter concludes by looking a elements that have been identified as promoting good practice for an intergenerational activity programme (IAP). The concept of intergenerational practice (IP) is making great strides in societies today with growing efforts to bring older adults and younger people together. As the concept IP has developed over the last 50 years, so to have the discussions surrounding its definition, structure and approaches used. These areas have unearthed debates amongst practitioners and researchers from different disciplines, backgrounds, and settings.

3.1. Clarifying terminology

Providing clarification on key generational definitions is essential when discussing and interpreting literature relating to intergenerational relations.

Generation

The concept of 'generation' can be used and interpreted in many ways, however at the most basic level, the term generation has two core meanings; (i) familial, which relates to kinship relations within one family e.g. a child with her mother, grandmother, or (ii) societal, which is a time bound phenomena linked to both individual and collective components such as age, historical events or socio cultural position (Keating et al., 2015, p. 2; Kaplan, Sanchez and Hoffman, 2017). Generations at a societal level, share three key components: shared birth period, shared exposure to common historic events and shared socio-cultural location (Gilleard and Higgs, 2002). This study focuses on IAP involving individuals from societal generations.

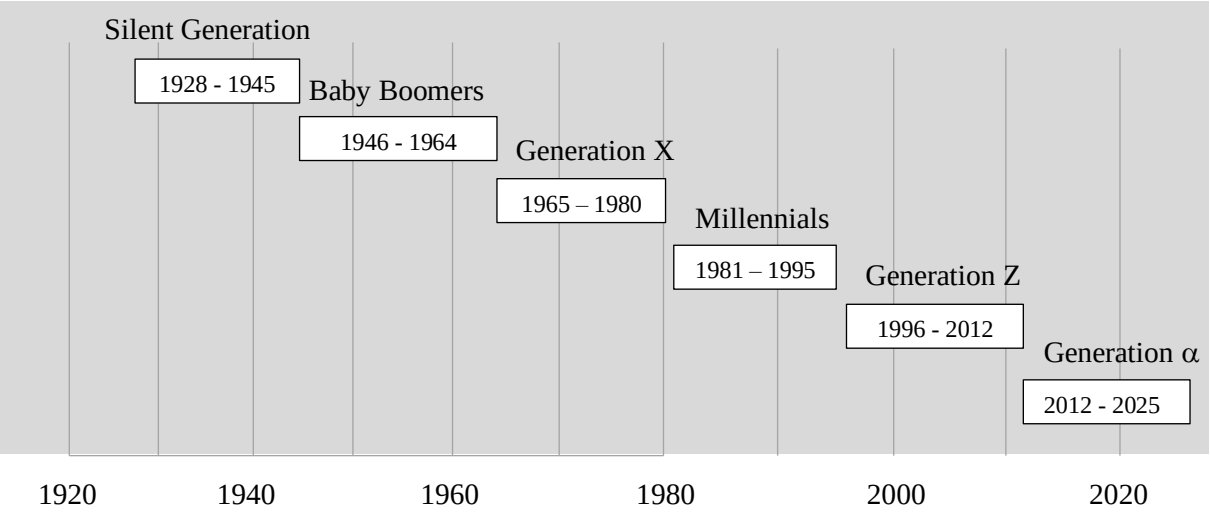
Intergenerational

The term intergenerational technically refers to the interaction between any two or more generations (Kaplan et al., 2017) (see section below *Intergenerational vs Multigenerational* for a more detailed discussion on this). In this research there are several intergenerational relationships that will be studied. Firstly, relationships between distant generations; the so called 'Silent generation' and 'Baby Boomers' (representing the care home residents cohort) and 'Generation Z' (younger people) involved in the intergenerational programmes. Secondly, intergenerational relationships between (chronologically) closer generations such as care staff

and family/friends of residents who may be categorised as ‘Baby Boomers’, ‘Generation X’, ‘Millennials’ and ‘Generation Z’ (**Figure *1***)

Figure 1

Generation time-points



Intergenerational vs Multigenerational

Kaplan and colleagues distinguish between intergenerational and multigenerational, by viewing the multigenerational label as simply the presence of one or more generations. While intergenerational focusses more on the purposeful bringing together of two ‘generation diverse’ groups to undertake activities and ‘activating new relationships that are rooted in the interaction process between generations’ (Kaplan et al., 2017 p 14). This study uses the line of inquiry whereby the role of the ‘middle generation’ is to facilitate the activities (Granville, 2002; Hatton-Yeo, 2006) and not to fully participate. However, being in the presence of such activities has been shown to have effects on the so called generation ‘X’ and millennials, although the literature base is small (Somers, 2019). The term intergenerational is used in this thesis

Intergenerational Practice (IP)

Granville (2002) stated that the term ‘intergenerational practice’ covers a wide range of activities and is only loosely defined. Such practices can act as a mechanism from which intergenerational relationships can be strengthened (Phillips, Ajrouch & Hillcoat-Nallétamby, 2010). Despite ongoing debates around a single definition of intergenerational practice and lack of clarity around the age of participants included, and the role of the middle generation

(Springate, Atkinson, & Martin, 2008) the Beth Johnson foundation provides one of the more commonly used working definitions, and one on which this thesis will be based:

> *"Intergenerational practice aims to bring people together in purposeful, mutually beneficial activities which promote greater understanding and respect between generations and contributes to building more cohesive communities. Intergenerational practice is inclusive, building on the positive resources that the young and old have to offer each other and those around them"* (Beth Johnson Foundation, 2001)

While other countries such as America and Spain have drawn on alternative definitions, they use similar key words such as intentionally, beneficial, inclusive, exchange and understanding. The differences in terms of definition of intergenerational practice is reflected in the different forms intergenerational practice can take. Summed up by the British researcher Gillian Granville as '*not a single approach, but a style of working that can lead to many different activities and outcomes'* (Granville, 2002, p. 26). This thesis uses the term intergenerational practice as a broader term, in which it encapsulates intergenerational activity programmes. A visual representation of intergenerational practice implementation levels adapted from (Kaplan, 2004, p7) illustrates the different type of contact that can occur between generations involved see table 2. Kaplan (2004) proposes a total of seven different levels or forms intergenerational practice can take in practice along a continuum starting from low level to high level. This continuum is helpful in providing a point of reference as to where intergenerational programmes discussed in the following literature review may sit and is an initial starting point when looking at variation in reviewed intergenerational programmes. I would refer the reader back to this continuum throughout this thesis.

Intergenerational activity programmes (IAP)

Intergenerational activity programmes (IAP) are defined as several prolonged but finite activity sessions between younger generations and older generations. For example, one weekly session over a period of two months. The continuum demonstrated in Table 2 highlights that it is only the contact described from level five onwards that we can truly consider an intergenerational programme. This is true within this thesis, with all of the intergenerational activity programmes evaluated in this thesis falling into level five. Levels six and seven describe the levels of intergenerational practice seen in other countries such as the United States and Japan who are more advanced in the intergenerational field (Gigliotti, Morris, Smock, Jarrott, & Graham, 2005; Weeks, MacQuarrie, Begley, Nilsson, & MacDougall, 2016).

Table 2

The depth of Intergenerational Engagement Scale

Situation	Level of Contact	Explanation
	Low	
1. Learning increased awareness of other age groups		No actual contact just increasing understanding and knowledge of other age group
2. Linking with other age group in-directly		Project participants find out about each other, e.g., exchanging biographies or photos
3. Meeting other age group		Meeting between group of younger and older age groups planned as a one-time event
4. Annual or sporadic meetings		Typically tied to community or organisational events, either group invited along, e.g., Christmas party, St.Davids day
5. Regular shared and structured activities		Consistent programme of events where both groups work together on shared activities
6. Integration of IG programme into organisations		On-going programmes have gained sustainable support and been incorporated into future working practices and approaches.
7. IG community settings		Meaningful intergenerational interaction is abundant and IG values are embedded into the culture of the setting in which they run.
	High	

Source: Adapted from Kaplan (2004, p7)

There are numerous formats for intergenerational programmes or practices which are evolving constantly. As to are the typologies being developed to classify them. According to Cohen-Mansfield and Jenson (2017) IP is largely based around five types which are distinguished by the generational direction of service provision:

1. Younger people assisting older adults (e.g. befriending and visiting)
2. Older adults assisting younger people (e.g. educational or mentoring settings)
3. Co-production (e.g. younger people and older adults working together to support the community)
4. Older adults and younger people engaging together in shared activities
5. Co located Shared sites (e.g. daily interaction of shared space or buildings).

There is a wide heterogeneity of IAP, such as reading (George & Singer, 2011; Isaki & Harmon, 2015), dancing (Belgrave, 2011; Canning, Gaetz & Blakeborough, 2020), mentoring (Newman, 1997; Varma et al., 2015), or play (Skropeta, Colvin & Sladen, 2014; Teater, 2016). This heterogeneity is also reflected in the range of settings for IAP, for example schools, universities, local community, third sector organisations, local governments, and care facilities and across urban, suburban and rural locations (Canedo-García et al., 2017; Hatton-Yeo & Ohsako, 2000; Kaplan, Liu, & Hannon, 2006). Studies looking at the impact of intergenerational activities tend to focus either on a specific participant group (younger or older participants) (Lee, Camp, & Malone, 2007; Lokon et al., 2012), or both generations (Martins et al., 2019). With a couple of exceptions, reviews are about non-familial interventions, often about young children and older adults. Rarely is the 'middle generation' mentioned.

A number of reviews describe the types of outcomes that might be expected from intergenerational interventions (Canedo-García et al., 2017; Martins et al., 2019; Bryer & Owens, 2019; Park, 2014). Organisations and services that employ intergenerational strategies to harness their potential impact often do so in response to the needs of the community they seek to serve. For example, IP run in schools tend to take the format of older adults assisting younger people with outcomes focused on learning outcomes, school behaviour and attitudinal change (Babcock, Beach, & Salomon, 2018; Chase, 2010; Cummings, Williams, & Ellis, 2004; Drury, Bobrowicz, Cameron, & Abrams, 2017). Some programmes are implemented to address and/or alleviate certain social issues such as combatting loneliness or improving psychosocial

factors amongst older adults (Baker, Webster, Lynn, Rogers, & Belcher, 2017; Fujiwara, 2016), while others more broadly try to improve general relationships and mutual understanding between older and younger generations (Burgman & Mulvaney, 2016; de Souza & Grundy, 2007). This is reflected in the range of outcomes targeted (Gualano et al 2018). As a result, the variability in terms of settings, intended outcomes, and duration of IP is vast, impacting upon the comparison of outcomes generated from research.

3.2. Literature Review Methodology

A scoping review was conducted to identify all articles demonstrating quantitative outcome measures of intergenerational programming. A scoping review is a systematic literature review that aims to map the key concepts underpinning a research area and the main sources and types of evidence available (Arksey & O'Malley, 2005). In contrast with other types of systematic reviews, it is essential to note that breadth rather than depth is the primary goal of scoping reviews (Tricco et al., 2016).

A scoping review methodology was deemed the most appropriate method as it allowed the researcher to explore a broad conceptual range of related intergenerational literature and provided scope to cover the range of intergenerational programming outcomes on the three stakeholder groups in this study (Peterson, Pearce, Ferguson, & Langford, 2016). This type of review can also be of particular use when a topic has not yet been extensively reviewed and can help to refine subsequent research inquiries (Mays et al., 2001).

Using the methodological framework outlined by Arksey and O'Malley framework (Arksey & O'Malley, 2005), the scoping review followed a five-stage process: (1) identifying the research question(s), (2) identifying relevant studies, (3) study selection (4) charting the data, and (5) summarizing, and reporting the data. The review also drew upon additional resources from grey literature published by a number of charities and foundations, in the form of reports and best practice guidelines/manuals. However, these were later excluded as they we deemed not specific enough to care settings by the researcher.

3.2.1. Identifying the research question

Starting with the first step of Arksey and O'Malley's framework, the population, intervention, context, and outcome (PICO) model was used to identify relevant components to include in the

research question. This helped inform and clarify appropriate selection factors, including the target population, intervention, context, and outcome (PICO) that reflected the research questions.

Table 3

PICO model components

Population	Intervention	Context	Outcomes
Older Adults	Intergenerational Activities	Care Homes	Psychosocial
Younger People	Meaningful activities	Nursing Homes	Wellbeing
Care Staff		Residential Homes	Relationships
Facilitators		Long term care	Satisfaction
			Attitudes
			Loneliness

Population: One of the key factors about the population included in this review was the age of the participant. Although the intergenerational practice involved younger people age 5-18 and older people aged 65+ years, the literature review was broader and included studies involving younger people between 0-25 years (see also, Granville, 2002) and older adults aged 65 years and over. This age was chosen for older adults as this is the generally accepted definition of 'old age' in Western cultures, including the UK (World Health Organisation, 2015). The inclusion of ages 0-25 years for younger people was to capture as much literature as possible given that the researcher was aware of the limit evidence base for intergenerational activity programmes.

Intervention: Non-familial intervention based intergenerational programmes only were selected for the review. This has been the most common focus of intergenerational programmes over the last 20 years (Hatton-Yeo, 2006). Research looking at kinship type interactions were excluded.

Context: Reflecting time and budget constraints of the researcher articles published earlier than 2000 were excluded to capture the last two decades of intergenerational literature. The start date of 2000 was chosen because the researcher felt this covered the major policy changes and practice advances of intergenerational practice the UK. The search focused on intergenerational

research in care home contexts only. IAP run in communities tend to focus on older adults who have greater capabilities to mentor (Newman, 1997; Scott et al., 2005; Varma et al., 2015), whereas care homes support older people who require more support than community dwelling individuals (Royal College of Nursing, 2010) and as a result the impact of IAP on community dwelling older people is likely to differ and will not be used in the review. A review by Skropeta, Colvin, & Sladen (2014) identifies three different types of IP care home contexts; centre-based visitation; shared sites; and single home care. This thesis focuses specifically on 'centre based visitation' (i.e. *'child care and aged care services are delivered separately and IG activities are conducted at designated time, and day with one generation being transported to the others principle place of care. '* (Skropeta, Colvin, & Sladen, 2014, p. 321) and shared site IAP models. There is a plethora of literature in the intergenerational space that makes reference to informal networks of care (Skropeta, Colvin, & Sladen, 2014). However, this research defined "care" as that which is given by nonfamily members and in formal care settings such as residential care homes and nursing homes.

Outcomes: Outcomes were related to the three different stakeholder groups included in this study related to the care home setting. These are outcomes related to older adults such as psychosocial, wellbeing and engagement in activities, care staff and facilitators outcomes were focused around job satisfaction, attitudes and younger people involved in IAP outcomes were related to attitudes and enjoyment.

By using PICO, the following overarching research questions were identified a) Can changes in quality of life of older residents; attitudes of younger people; care workers' job satisfaction; and social engagement between these groups be demonstrated through participation in, or connections with an intergenerational program delivered in a care home? And, (b) What are the underlying processes of an effective and socially engaged intergenerational programme that improves connections and communication, promotes meaning and enhances well-being?

3.2.2. Identifying relevant studies

The next stage of the scoping review built on the components clarified by the PICO model (Table 3) and the rationale for study inclusion parameter. The researcher was able to formulate specific search terms for each target population in order to identify studies relevant to the

research question. After testing multiple combinations of search terms and pairings related to IG programmes, Articles were collected using combinations of the independent main subject terms with the following search was applied to each database:

- title: (intergenerational OR inter-gen OR multigene*)
- title: NOT grandparent
- title: NOT kin
- title: NOT familial
- title: NOT grandchild
- title: AND (program* OR practice OR engagement OR activity OR activities OR approach OR interaction OR model OR project)
- all text: AND (older adult OR geriatric OR elder OR senior OR elderly OR care home OR residential care OR aged care OR care staff OR activity coordinator OR children OR younger people OR outcomes OR evaluation OR effects)

The search terms were systematically entered into Swansea University Library's iFind search engine. The iFind database enabled searches to be carried out in multiple databases which included Web of Science, ASSIA, IBSS, JSTOR, PsychINFO, SCIE, Science Direct (Elsevier), Scopus. Secondary searching techniques (the Internet – google scholar, reference databases, and citation indexes) were also used to further broaden the search. Peer-reviewed professional journals, books, and other relevant sources from diverse disciplines as sociology psychology, anthropology, nursing, community health were included in the review.

Literature searches were undertaken continually throughout the duration of the research to ensure that the most current findings and literature has been included, as it is important to recognise the research as a 'live' piece of work and an "evolving resource" (Hart, 2018, p. 2). Systematic reviews, meta-analyses and randomised control trials were considered the most robust forms of evidence. An initial search was conducted in October 2018, and a subsequent search was carried out in January 2021. Searches were restricted to peer-reviewed journal articles only. This was to ensure a consistent baseline quality control of papers included in the review. Due to the limited evidence base of intergenerational literature, grey literature was considered but decided against for this reason.

3.2.3. Study Selection

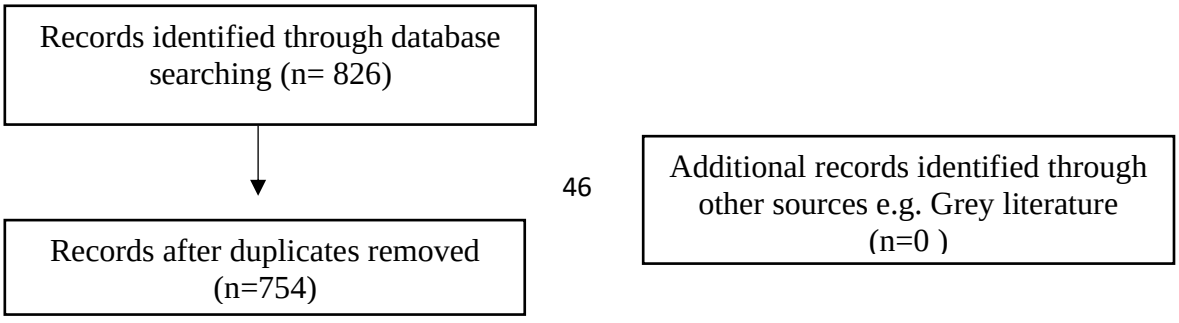
In order to preclude the search from identifying large numbers of irrelevant studies, similar to a systematic review approach this scoping review used the inclusion and exclusion criteria outlined above in relation to the PICO components. A PRISMA diagram of the search strategy is illustrated in Figure 2. Reference lists of included articles were searched for additional relevant references. Systematic reviews that were highlighted by the search process were also used to identify further potential. Figure 2 presents a PRISMA diagram summarising the steps that led to the final 16 articles chosen for full review.

Full-text articles that met all inclusion criteria and appeared to represent similarities with the research question were eligible for data extraction. The screening and selection of items for full review was initially conducted by a single researcher. Following the study selection, relevant data including study design, location, population, intervention type, duration, and frequency of contact moments were extracted. Additional data exploring the measurements for older adults, younger people and care staff were drawn out. Data on the following items were extracted: author(s); year of publication; country; participants included in findings; methods; details of activity programme (Type of activity; duration), outcomes; and limitations.

After the removal of duplicates the online database search returned 793 references unique titles and abstracts. After the first screening of the results, 641 studies were deemed irrelevant, 152 articles were identified as potentially relevant. Full text screening resulted in 16 suitable articles for full final review. In terms of looking at the quality, the researchers looked at key things such as the sample size, the study design (control group, testing across different time points). The level of description they went into in terms of study, sample selection, ethics, and whether they captured the number, duration and context of sessions and activities. The additional grey literature search identified no additional peer reviewed sources that met the eligibility for inclusion. An overview of the results is presented in Table 4, section 3.4.

Figure 2

PRISMA flow chart detailing the process of searching and identifying relevant papers



3.2.4. Charting the data

When looking at the articles a ‘narrative review’ (Pawson, 2002, p. 171), enabled the researcher to take a broader view including recording information about the ‘process’ of each programme or intervention in order to contextualised the outcomes presented. The data from the selected studies was input into a spreadsheet using excel, which included the following information headings: author, country, number and type of participants included in findings, methods, details of activity programme (type of activity; duration), outcomes and limitations. There appeared to be two forms of intergenerational activities that emerged from the studies included in the review; visitation based and shared sites. The reporting of the data is split into outcomes related to the stakeholders included in this study; older adults, younger people and care staff.

Table 4

Overview of studies included in the review of outcome specific literature

Author, year and country	Participants included in findings	Methods	Details of activity programme (Type of activity; duration)	Outcomes	Limitations
Shared site based IAP studies (n=7)					
Low, Russell, Mcdonald, & Kauffman, (2015) Australia	40 OA 20 in IG group and 20 in usual care)	Quasi experimental design Mixed methods	Reminiscence, 45 minutes/week for 12 weeks	Increase in enjoyment and passive engagement compared to usual care. No changes in quality of life (LTC-QOL) No change in agitation No change in sense of community Process evaluation, all went as planned	Small sample size Unblinded assessors Missing data
Heyman, Gutheil & White-Ryan (2011) United states	32 YP	Repeated measures within subject design Mixed methods	Spontaneous daily interactions, monthly large group interactions.	Improvement in CATE scores – More positive attitudes in IG group compared to control	Small sample size
Doll and Bolender (2010) United States	42 OA (21 intervention, 21 in control group)	Repeated measures between subject design Mixed methods	The “Age to Age” IG programme with interactions between OA and nursey children	Pain measure Activity of Daily Life (ADL) Mood State, Quality of life (QoL) No significant differences in quantitative measures. Improvement in quality of life from focus group.	Single site Small sample size
Holmes (2009) United States	38 YP (pre school) 3 CS	Repeated measures within subject design Mixed methods	Range of activities 1 hour sessions	Knowledge about ageing improved Increased used of positive descriptors to depict older adults	No used of standardised measures

Table 4

(continued)

Author and country	Participants included in findings	Methods	Details of activity programme (Type of activity; duration)	Outcomes	Limitations
Lee, Camp & Malone (2007) United States	14 OA 15 YP	Randomised control trial	Shared site, Montessori-based activities 20 minutes twice a week for a year (6 months each group: While one was engaged in IG activities other group acted as control)	More constructive engagement during IP Lower levels of negative forms of engagement compared to standard activities Regression to baseline levels after intervention.	Quality of the interactions was not assessed
Jarrott & Bruno (2007) United States	39 OA	Repeated measures within subject design Mixed methods	ONEgeneration Daycare – Residential care setting	OA enjoyment of the sessions OA reported being happy (97%), interested (90%), loved (89%) and needed (86%) when around the children. 21 OA stated there was something they did not enjoy, including noise.	No control group Single site
Gigliotti, Morris, Smock, Jarrott & Graham (2005) United States	OA YP 6 CS	Mixed methods	Shared site, IG Summer programme 4 days a week for 10 weeks over a 13 week period	YP able to learn empathy and less judgemental of OA Increased staff development and sense of self	No used of standardised measures Single site No control group Unknown number of older adults and younger people included in sessions

Table 4

(continued)

Author and country	Participants included in findings	Methods	Details of activity programme (Type of activity; duration)	Outcomes	Limitations
Visitation based IAP studies (n=9)					
Canning, Gaetz, & Blakeborough, D. (2020). Canada	7 YP	Qualitative Repeated measures within subject design	Visitation Dance programme 60 minutes per week over a 6 month period	Prior IAP YP anticipated their dance partners to be unwell and unable. After, YP described the residents much more positively highlighting their abilities and strengths. Children's views of disability and difference disappeared as they formed dance partnerships and developed meaningful relationships.	Single site Small sample size No control group
Di Bona, Kennedy & Mountain (2019) England	10 OA 41 YP 8 CS	Mixed methods	Visitation, reminiscence/life story Unknown number of sessions	Staff reports of OA positive experience Increased empathy and understanding of dementia by YP Sharing of stories with families outside of project Positive changes to personal development	No detail of number, frequency, and length of sessions provided. Single site
Baker et al (2017) Australia	24 OA 59 YP	Mixed methods Repeated measures within subject design.	Visitation, technology, 4 visits over 15 weeks; visits 1-3 lasted 40 minutes, visit 4 lasted 90 minutes	OA felt more positive and less negative present moment affect (eg how sad, happy, calm, anxious etc) after IAP. IAP particular benefit to OA with greater cognitive impairment Process evaluation	Single site; Limited face to face contact with YP; Engagement was rated by care staff, non-blinded; Only the in the moment affect captured.

Table 4

(continued)

Author and country	Participants included in findings	Methods	Details of activity programme (Type of activity; duration)	Outcomes	Limitations
Isaki & Harmon (2015) United States	6 OA 12 YP (School aged)	Pre-post design Mixed methods	Visitation, (Assisted living), Reading 45 minute sessions for 8 weeks	Enjoyment, improvement in reading behaviour. Significant improvement in perceptions of OA viw Children's Views of Ageing questionnaire (CVOA) pre/post IAP	Small sample size No control group
Skropeta, Colvin, & Sladen, (2014) Australia	48 OA	Repeated measures within subject design Mixed methods	Intergenerational playgroup 90 minutes per week Multiple sites (n=3)	No significant difference in quality of life (SF-36) or GDS Qualitative themes 1) Intergenerational experiences 2) Two-way contributions 3) Friendship work 4) Personal growth 5) Environmental considerations	No control group No subgroup analysis of depressed and non-depressed participants. No total participation rate for each session when attendance was optional.
George & Singer (2011) United states	15 OA	Repeated measures between design Mixed methods	Visitation Singing, reading, reminiscence, writing 60 minutes per week	Decline in stress in IG group compared to increase in stress in control group; No significant difference in cognitive ability compared to decline in control group. Greater decline in feelings of depression in control group compared to intervention Enhanced QOL through reduction in stress and key themes of mechanisms of impact in relation to QoL: 1.Perceived health benefits 2. sense of purpose & usefulness and 3. Relationships	Small sample size

Table 4

(continued)

Author and country	Participants included in findings	Methods	Details of activity programme (Type of activity; duration)	Outcomes	Limitations
McNair & Moore (2010) United States	39 OA 29 YP	Quasi experimental Mixed methods	Visitation Specialised care unit in long term care facility	Increased levels of comfort with OA and enjoyment More positive perceptions - drew more positive pictures of the OA and more personalised responses compared control No significant changes on CVOA	Small sample size Convenience sampling
Chung (2009) China	51 OA 117 YP	Repeated measures within subject design Quantitative methods	Visitation, Reminiscence 90 minutes a week for 12 weeks	Overall improvements in mean scores on the Chinese versions of MMSE and QoL-AD. Decrease in depression score	Small study with a convenience sample No control
Bales et al (2000) United States	63 YP	Repeated measures within subject design Qualitative methods	Visitation, Pen pal letters, chorus	2nd and 4th grade YP significant improvement in positive descriptions of OA. Decrease in negative words No different in 5th grade YP	Single site

3.2.5. Summarising the data

The literature on IAP in care homes is, far more scarce than those run in schools and community settings (Peters, Ward, Kenning, Radford, Goldwater & Rockwood, 2021). Educational settings are the most commonly cited context in which IAP are run (Babcock et al., 2018; Canedo-García et al., 2017; Kakuma & Kusano, 2009; Whitehouse, Bendezu, Fallcreek, & Whitehouse, 2000). However, IAP are increasingly being introduced into care home settings (Di Bona, Kennedy, & Mountain, 2019; Low, Russell, Mcdonald, & Kauffman, 2015) in order to support individual needs and meet wider social and societal goals. Studies on IAP that include participants who have dementia are rare.

There are fewer articles looking at IAP implemented in care homes than in community settings such as day care services or schools. From the combination of terms and searches conducted, 16 articles addressing IAP conducted in care homes were identified for inclusion in this literature review. The review highlighted a range of activities carried out during IAP in care home settings, including reading (Isaki and Harmon, 2014; George, 2011), singing (Bales et al., 2000; George, 2011), playing games (Low et al., 2015), and reminiscence (Chung, 2009); using both structured (Lee, Camp & Malonem 2007; Jarrott et al., 2011) and unstructured formats (Heyman, 2011), with some using a mix of both (Skropeta et al., 2014).

The type of IAP run in care home settings also took two forms; visitation based, where younger people or older adults visit each other for the session and return to their respective institutions or shared site where '*older adults and young people receive services at the same site and both generations interact during regularly scheduled intergenerational activities, as well as through informal encounters*' (Generations united, 2018). Shared site IAP have a major logistical advantage; minimising the need for transportation of participants to relevant sites and improved/increased spontaneity of interactions (Lee, Camp & Malone, 2007; Holmes, 2009). All shared site studies included in this review were from the United States, this approach to IAP has not typically been used in Wales to date. The main features of the collected works are reported in Table 4. The outcomes and details of these studies in relation to older adults, younger people and care staff are discussed in the following sections below.

The theories underpinning the studies varied. Studies by Jarrott & Bruno (2007) and Gigliotti, Morris, Smock and Jarrott (2005) were based on the theories of personhood (Kitwood, 1997), and contact theory (Allport, 1954). Skropeta and colleagues (2014) used symbolic interactionism to interpret their findings. In line with Skropeta and colleagues theoretical positioning of IAP, outcomes from this literature review revealed a string of symbolic interpretations relating to the outcomes of the studies drawn upon in this review. For example, symbolic elements of body language and objects drawn upon by Di Bona and colleagues, and a study by Gigliotti et al., (2005) that explored outcomes from a IG summer programme run over two consecutive summers where staff reported they had to be 'intentional' with the pairing up of OA and YP in order to maximise positive interactions highlighted the symbolic representations of individuals personalities affecting interaction (Gigliotti et al., 2005).

Older Adults (OA)

Twelve of the sixteen papers included in the review looked at the impact of IAP on OA residing in care facilities. Eight were from US, (Low et al., 2015; George & Singer, 2011; Doll and Bolender, 2010; McNair & Moore, 2010; Chung, 2009; Lee, Camp & Malone, 2007; Jarrot & Bruno, 2003, 2007; Gigliotti et al., 2005) two from Australia (Skropeta et al., 2014; Low et al., 2015), one in England (; Di Bona et al, 2019) and one in China (Chung, 2009). Of these, seven were in relation to shared site IAP, and nine explored outcomes from visitation based IAP.

One of the shared site studies used Montessori-based methods (Gigliotti et al., 2005; Lee et al., 2007). Montessori-based methods originated in educational settings. Montessori Intergenerational Learning Communities (MCIL) are common practice in the United States and have generated a substantial amount of research from these practices. MCIL enable older adults to provide support with school based curricular activities (Cummings, Williams, & Ellis, 2003). Activities are broken down into different elements and the capabilities of participants are matched to the task. In care homes, such activities can provide opportunities for participation and independence for older adults.

The MCIL structured approach to delivering a programme of activities combined with the presence of younger people helps foster positive and engaging environments for people living with dementia (Lee et al., 2007). This was demonstrated in a study evaluated by Lee et al., 2007 during which IAP was run in a range of settings, including a residential home on a shared site. The study involved 14 residents with dementia and 15 younger people from the onsite

nursery. Montessori based IAP sessions lasted around 45 minutes and were delivered twice a week for six months. These were compared to a control group of residents who were engaged in a regular activities programme. After six months participants in the control group switched to IAP sessions, and the participants in the IAP sessions switched to the control group, engaging in regular activities. Observational data on engagement using the Myers Research Institute Engagement Scale (MRI-ES) (Judge, Camp, & Orsulic-Jeras, 2000) collected before, during and after the intervention revealed that older adults engaged more constructively, with less passive engagement when the younger people were present. More specifically, the research highlighted that on average, residents in the IAP were engaged in the activities five time longer than those receiving regular activities.

Similar outcomes were found in other shared site IAPs, whereby participants enjoyed the IG sessions more (Doll and Bolender, 2010; Low et al., 2015), and passive engagement appears to decrease (Low et al., 2015) compared to those who received care as usual IAP. Low et al (2015) conducted one of the two randomised control trials included in this review, The 'Grandfriend programme' was a shared site based IAP, co-developed by school staff, nursing home staff and the research team (Low et al., 2015). In this IAP children were paired with a 'Grandfriend' and participated in a range of activities in the onsite co-located nursery for 45-minute sessions over a 12-week period. Three validated measures, including Cohen-Mansfield Agitation Inventory (CMAI) (Cohen-Mansfield, 2005), the Brief Sense of Community Scale (BSCS) (Peterson, Speer, & McMillan, 2008) and the Long Term Care Quality of Life Scale (LTC-QoL) captured older adults, quality of life, agitation and sense of community. Although, as noted above, there was a decrease in passive engagement and increased enjoyment compared to those who received care as usual, results before and after the intervention demonstrated no changes to quality of life, agitation, or sense of community in comparison to randomised controls. The process evaluation showed that although the sessions were run as planned, of 20 older adults enrolled only four attended all of the 12 sessions. This meant 'Grandfriend' pairings were not consistent across the study.

Another shared site case study by Jarrott and Bruno evaluated the ONEgeneration IAP which had been operating for 13 years. The site consisted of two day care centres (one for older adults and one for children) joined by a 'breezeway' which people used to get to the other centre without going outside. Activities with intergenerational components took place in both centres offering several opportunities for intergenerational interactions throughout the day. A range of

activities were run, from bingo to baking and included having lunch together. The study suggested that YP typically attended the shared site day care for five days a week and had one or two IP options a day; older adults typically attended the SSIP for three and a half days a week and had multiple IG options a day. Researchers conducted interviews with 39 older adults with dementia who took part in the intergenerational activities, exploring the likes and dislikes of the programme. They used open ended questions supported by the use of yes/no responses for those that struggled to respond. In total, 97% indicated that they benefited from the IAP, with children's playfulness highlighted as a key source of enjoyment (87%) for those interviewed. Although feedback was predominated by positive responses, stakeholders did identify drawbacks and dislikes. These are discussed later on in this section. Doll and Bolender (2010) also looked at the impact of IAP on nursing home residents with a co-located nursery. In this study, younger and older participants had several opportunities to interact with each other on a daily basis. While mood was enhanced and qualitative data found improvements in quality of life these were non-significant.

Engagement opportunities and the duration of intergenerational contact has been shown to be greater in shared site studies (Gigliotti et al, 2005; Lee, Camp & Malone, 2007, Doll and Bolender, 2010) compared to visitation studies (Baker et al 2017). However, the quality of the interactions between generations were not captured (Lee, Camp & Malone, 2007). Similarly, with the Montessori based IAP disentangling the effects produced as a result of the intergenerational or Montessori element was a challenge in these studies (Lee et al., 2007).

Moving on to consider visitation based IAP, 7 articles examined the impact of these activities on care home residents. One visitation based programme, The Avondale Intergenerational Design Challenge (AVID), connected technology students with residents (who had cognitive impairment), four times over a 15 week period (Baker et al., 2017). The first three visits lasted 40 minutes and the last session lasted and hour and a half. The project consisted of students getting to know the residents' hobbies, values and beliefs in order to co-design an object or artefact which the student produced as a final product. The overall objective was to '*get to know the resident through conversation and reminiscence and to use their technology skills to create something meaningful for the resident based on individual needs and preferences*' (Baker et al., 2017, p. 214). Artefacts created included a timber knitting wool box, a handmade quilt and customised objects such as a stable table for a resident's wheelchair, and a personalised jewellery box. Engagement was rated by care staff. Individuals with cognitive

impairment used Likert-type face scales to rate the present moment effect of IAP, which was measured prior to and post visits from the student for sessions 2, 3 and 4. The study demonstrated that people living with dementia reported greater positive affect following involvement in the IG activities compared to usual activities. All residents were significantly more engaged especially those with increased cognitive impairment. However, the reliability of the outcomes in relation to engagement are questionable, as engagement was rated by the facility care staff who were not blinded to the purpose of the study. Furthermore, as with many of the IAP evaluations the sample size was small, and there were few visits across a long period which equated to only 3.5 hours of face to face contact time with YP. In addition, the study focused on immediate in the moment affects rather than longer lasting impact outcomes via the use of a single item affect measure.

Qualitative data exploring the impact of visitation based intergenerational activities on quality of life seems to suggest improvements (George, 2011; Di Bona et al., 2017). Sheffield county council initiated a visitation IAP. This was intended to make Sheffield more dementia friendly. The 'Adopt a Care Home' programme was one of the first in the United Kingdom to connect school children with residents who were living with dementia (Di Bona, Kennedy, & Mountain, 2017). It involved 10 residents who were living with dementia and 41 school children age nine and ten. The programme had three key aims; i) to enhance children's awareness of dementia, ii) to enhance the wellbeing of the residents involved and iii) to explore the safety and feasibility of the programme. The impact on younger people is discussed below. Although the study utilised mixed methods, outcomes relating to older adults were explored using purely qualitative methods including; observations, semi structured interviews and focus groups. The researchers suggested that it was '*enjoyable for most participants*' (Di Bona, Kennedy & Mountain, 2019, p.1), observations of positive body language, for example smiling faces and residents described as bright eyed, with lots of laughter were used to support this statement. Care staff reported that some residents who were often restless and agitated demonstrated much more engagement than normal, and reduced disruptive behaviour when the children were present (Di Bona et al., 2017). In contrast to Low et al (2015), Di bona and colleagues found that the severity of dementia did not affect the ability to participate in the activities.

There were several limitations associated with this 'Adopt a Care Home' study. The authors provided an account of challenges faced in implementing the programme, however there were no details on number, frequency, and length of sessions. The researchers themselves recognised

the succinct nature of this evaluation stating that it was *'brief and pragmatic and did not aim to gain an in depth understanding of the experiences and effects on all participants'* (DiBona & Kennedy 2015, p.3). Although observational data enables researchers to explore behaviours and experiences of participants who may experience challenges reporting on their own experience, they are open to misinterpretation of the participants experience. In this study observations, were not conducted using a validated observational instrument, nor were they triangulated with other forms of data. In contrast, Jarrott & Bruno (2007) supplemented observational data with self-report (interviews) completed by individuals living with dementia.

Quality of life for older adults with dementia was also explored in another visitation IAP. A pre post, mixed method, RCT was used by George (2011) to examine an intergenerational volunteering programme and the impact on the quality of life. This study included a control group and consisted of hour-long sessions over a period of 5 months. Intervention one was with children aged 5-6 and consisted of activities such as singing, small group reading and writing. Intervention two was with slightly older children age between 11 and 14 years and had a focus on intergenerational life history and reminiscence aspects. Both interventions comprised of small groups of two to three children. Whilst this study reported a significant reduction in levels of stress in the intergenerational group, no changes were found in relation to cognitive function or depression. Instead of a focus of the type of activity, relationships were identified as a key mechanism for improved quality of life. Researchers noted that the relationships formed with individuals from outside the care setting drew residents away from focus on ailments and anxieties, helping to mitigate feelings of social exclusion. The participants in this study were taken out of their usual environment for the intervention, which may have contributed to the observed outcomes. This study was one of the very few IAP randomised control trials that included people diagnosed with dementia. However, it did not use standardised quality of life measurement scales and excluded those with severe depression or anxiety.

A study that explored outcomes from an IG summer programme run over two consecutive summers highlighted the influence of individuals' personalities on interaction. For example, staff reported they had to be 'intentional' with the pairing up of OA and YP in order to maximise positive interactions. Overall numbers of each of the stakeholder groups who took part in the study was not disclosed. This study did daw on a range of qualitative methods to triangulate the data, these included interviews, evaluation forms and parent surveys. Meaningful relationships between certain OA and YP were highlighted as a key outcomes,

researchers related the development of relationships and general enjoyment of each other's company as affirmation of 'both participants groups' sense of self and enhanced quality of life' (Gigliotti et al., 2005). However, no direct measures of quality of life however were recorded.

Another visitation IAP study conducted in China by Chung (2009) included more quantitative outcomes, compared to other visitation IAPs included in this review (Di Bona et al., 2017; Gigliotti et al., 2005). The outcome measures used in this particular study are similar to those used in this thesis, and assessed participants with early dementia on three outcome measurements completed pre and post intervention: the Chinese versions of The MMSE, the Qol-AD, and The Geriatric Depression Scale (GDS). In total 51 OA were recruited from 8-day care centres across Hong Kong to engage in 12 weekly visits by YP to OA, lasting 90 minutes. OA were allocated to small groups of students to discuss life experiences and to make personalised life story books. Interactive props and activities were used to support the sessions and interaction. The study found an overall improvement in all three measurements taken: QoL, cognitive function, and a reduction in depression scores across the 12 weekly sessions. However, the assessments in this study were completed by a proxy, meaning that the voice of the those with dementia was not included. Furthermore, there is a lack of clarity around how the YP were recruited.

Skropeta, Colvin and Sladen (2014) looked at an intergenerational playgroup programme run across three care home facilities in Australia, with children age between 0 and 4 years old and the children's carers. The sessions included structured and unstructured activities such as finger painting and learning experiences. Sessions lasted one and half hours and took place on a weekly basis. Residents were screened via the Mini Mental State Examination (MMSE). This showed that 85% of the 48 OA who participated in the IAP experienced mild to severe forms of dementia. The study looked at the impact the programme had on residents' levels of depression (GDS) and quality of life (SF-36). The results revealed no significant change in GDS scores but one significant change amongst the SF-36 sub scales; a decrease in energy. Authors suggested this change could be partly due to the general age of the participants (m=85). Findings from the qualitative aspects of this study highlighted positive intergenerational experiences, friendships, two-way contributions, and personal growth. Skropeta and colleagues suggested that whilst the quantitative impacts were minimal, the programme 'increased dignity of older people and people with dementia within the community' (Skropeta et al., 2014, p. 9) by providing meaningful forms of engagement. However, with a small sample size (n=41) and

no comparison between locations (despite the duration of programmes varying between them) it remains difficult to draw conclusions. Further to this, the authors did not report participation rates of each session and attendance was optional. Similar to the study by Baker et al (2017) this pre post designs only captures the short-term impact of IAP and does not determine whether outcomes change once the activity programme has ceased.

Outcomes have not always been found to be positive in relation to older adults involvement in IAP within care settings. For example, Posada (2006) paired children with nursing home residents for 10 minute sessions, three times a week over a nine week period. The study examined levels of depressive feelings and positive behaviours demonstrated by the older adults. Feelings of depression actually increased in both the intervention and control groups over time, despite observations highlighting an increase in positive behaviours during interactions between the YP and older adults.

Despite a number of studies reporting that older adults report enjoyment when engaging with IAP (Lee, Camp & Malone, 2007; Low, Russell, McDonald & Kuaffman, 2015; Di Bona et al, 2019), a study by Jarrott and Bruno (2007) evaluating the One Generation Shared Site Scheme found mixed findings around older adults' enjoyment. This scheme involved children between the ages of six weeks to 6 years and 'frail' older adults (Jarrott & Bruno, 2007). Children's stimulating energy and playfulness were highlighted as a positive. Other benefits included feelings of happiness (97%) and feelings around being loved and needed. Conversely, nearly half of the older adults (54%) indicated that there were things they didn't like about being involved, these included; noise, children's impoliteness and commotion. Low and colleagues also highlighted some negative views of IAP. Some older adults agreed to participate but then refused to attend sessions when the opportunity arose, while another older adult participant said '*she thought that the children should be at home with their mothers'* (Low et al., 2019, p 237).

Older people with dementia are often excluded from IAP because there is a perception that they may become agitated and aggressive and there is a general misunderstanding of the capabilities of such individuals (McNair and Moore 2010). Researchers suggest this is part of a cyclic process where low levels of engagement, lead to feelings of boredom and loneliness that potentially lead to challenging behaviour (Cohen-Mansfield, Marx &Werner 1992). Generally, studies demonstrated increased levels of positive engagement and enjoyment

amongst older adults living with dementia when interacting with younger people (Lee, Camp & Malone, 2007; Low, Russell, McDonald & Kuaffman, 2015; Di Bona et al, 2019). Further to this, studies also identified reduced levels of disruptive behaviours (Di Bona et al., 2019) and enhanced quality of life for people living with dementia and engaged in IAP (Gigliotti at al., 2005; George, 2011; Di Bona et al., 2017). There were, however, some mixed findings in relation to the reduction of agitation (Low et al., 2015) and improved quality of life (Chung, 2009; Skropeta et al, 2014; Low et al., 2015). Many of the studies included in this review only included data that were observed when the intervention was in action. It is unclear whether any benefits for people living with dementia extended beyond the intervention; i.e. whether these outcomes lasted. Furthermore, data often comprised subjective observations made by the researcher, or used proxies, meaning the voice of older adults with dementia was absent.

Younger People (YP)

The construction of younger persons attitudes toward older people at an early age, lays the ground for their future self-concept, psychological well-being, and social cohesion. All of which are increasing important in an ageing world. In relation to this the literature the most frequent outcomes explored were; younger people's attitudes towards older adults and younger peoples knowledge of and comfort with dementia. Seven of the studies discussed in the previous section also included results on the impact on younger people (Gigliotti, et al., 2005; Jarrott & Bruno, 2007; Chung, 2009; Mc Nair & Moore, 2010; Isaki & Harmon, 2015; Baker et al., 2017; Di Bona et al., 2019). There were four additional intergenerational studies that focused on outcomes relating to younger people who were involved in an IAP in care homes specifically (Bales et al., 2000; Schwalbach & Kiernan, 2002; Holmes, 2009; Heyman, 2011; Canning et al., 2020). Of these four were from the US (Bales et al, 2000; Schwalbach & Kiernan, 2002; Holmes, 2009, Heyman et al., 2011); and one from Canada (Canning et al., 2020). The majority of these studies were visitation based IAP with four shared site IAP studies included (Gigliotti et al., 2005; Jarrott & Bruno, 2007; Heyman, 2011; Holmes, 2009).

Social and emotional development were demonstrated in an IAP in which the primary outcome was changing '*attitudes*' of younger people (Bales et al., 2000; Heyman, 2011). To assess the attitudes of younger people a number of studies used a repeated measure pre and post design with interviews or questionnaires completed across different time points. Of the shared site

studies included in this review all three looked at attitudes of younger people towards older adults.

Two of the shared site studies discussed in relation to older adult outcomes also explored the impact IAP had on the younger people involved. Gigliotti and colleagues used facilitators' reports of the younger people aged between two and ten to gain insight into their experiences. Researchers provided parents with surveys and were asked if and how their child benefited from involvement in the IAP. More specifically, researchers asked them to detail the formation of any 'special relationships'. Parents suggested that the IAP created 'fun learning environments' (Gigliotti et al. 2005, p432) enriching the lives of older adults and younger participants. The benefits to relationships were described as 'numerous', with strong meaningful relationships develop between specific older and younger participants, for example one parent commented '*our daughter seemed attached to [Resident] he usually told her father all about George and how he helped her with an art project'* (Gigliotti et al. 2005, p433. Connections and relationships were sustained demonstrating a longitudinal impact. The case study from (Jarrott & Bruno 2007) also outlined previously found that YP enjoyed the interaction with the OA, and in particular the 'individualised attention' they received from the older adult residents. However, much like Gigliotti et al (2005), younger peoples experiences and thoughts on the programme were captured through the carers of the younger people. This proxy measurement is a limitation of both of these shared site studies.

Holmes (2009) evaluated the first year of implementation of a shared site IAP, in which a nursery was located in the same building of the nursing home facility. Intergenerational activities were planned and offered on a regular basis. Researchers found that prior to the IAP half of the younger people used negative descriptors to describe older adults. However, after a year of participating in intergenerational activities all of the younger responded with positive descriptors. This research also supported findings from Jarrott & Bruno (2007) that suggest IAP can meet the needs of individuals more effectively with enhanced individual attention. Comparable outcomes looking at changes in descriptions of older adults by younger people were assessed in a further shared site study (Heyman et al., 2011).

Using a static group comparison design of a shared site IAP compared to younger people in a traditional day care setting Heyman, Gutheil and White-Ryan (2011) assessed nursery age children's attitudes toward older adults. Findings suggest that when younger people were

shown pictures of older adults and asked to describe their attributes, younger people in the IAP held more positive views of older adults compared to the traditional programme. In particular, younger people in the IAP viewed older adults as healthy, which was in contrast to younger people in the traditional day care setting. In addition to pre and post study design, a handful of studies used a control group to strengthen their findings (McNair &Moore, 2010; Heyman, Gutheil and White-Ryan 2011).

In contrast to the shared site studies, a study by McNair and Moore (2010) showed no significant changes when comparing the pre and post attitudes using the Children's Views of Aging attitudinal survey (CVOA). However, the younger people shifted from feeling afraid and anxious of interacting with the older adults prior to the IAP, to much more positive associations of older adults after the programme. Furthermore, the younger people also expressed enjoyment, greater levels of comfort with the older adults and indicated that they had grown personally from the time they had spent with the older adult residents. Although personal growth and development in terms of confidence communicating with older adults was shown to improve in other visitation based IAP studies (Di Bona Kennedy & Mountain, 2019; Canning et al,. 2020), this particular study by McNair and Moore (2010) was unique in that it included adolescents with learning difficulties. The study with adolescents with learning difficulties found that the type of activities were important in determining positive outcomes. This conflicts with previous research that suggests it is the intergenerational component that makes the interventions successful as opposed to the specific intervention (George, 2010; Galbraith, Larkin, Moorhouse, & Oomen, 2015).

The art based 'Imagine Dance Programme', which integrated a dance movement therapy with an intergenerational component, was carried out in a residential care home in Canada (Canning, Gaetz, & Blakeborough, 2020). Participants were partnered up at the start of the intervention, with the same partnerships continued throughout the course of the programme. The study used field notes, video recordings, observations and interviews with the younger participants to explore their perceptions of ageing and relationships. Of the fifteen participating older adults, eight had mild to moderate dementia and seven had severe dementia. Younger people were interviewed three times over the course of the six month period. Results from weekly sessions over these six months revealed that younger peoples' perceptions of older adults positively changed in line with the development of meaningful relationships with the residents. Descriptions used to refer to the older adults shifted from negative stereotypical ones to ones

of respect value, and ability of the older adults and support other studies (Bales et al., 2006; Chung, 2009; Di Bona et al., 2010; Heyman et al, 2011).

The 'Learning and Growing Together Intergenerational Programme' also assessed attitudes of younger people; Sixty-three second and fourth grade children were asked to provide descriptors (categorized either as positive, negative, or physical) for older people, both before and after the IAP. Results indicated a significant increase of the number of positive words used to describe old adults. There was also a decrease in the number of negative words used in descriptions. However interestingly there was no difference found in relation to 5th grade age younger people (Bales et al. 2006). Additionally, in Britain, a study by Di Bona et al. (2017) examined the influence IAP had on younger people's awareness and understanding of dementia. Consistent with findings from (Chung, 2009) which highlighted more positive perceptions of dementia by younger people using a dementia quiz. Younger people in Di Bona et al's study also increased basic knowledge of dementia, with many able to describe signs and symptoms of dementia and an understanding that currently there is no cure. However, some uncertainty around the cause of dementia remained for example one younger person asked "Can you catch it? Is it a virus?" (Di Bona et al., 2019, p20). Despite this, the researchers noted that there the children unanimously believed that people with dementia should be treated with kindness.

As well as a greater understanding of dementia by younger people, Di Bona et al's (2019) study of a visitation programme also demonstrated increased empathy through reminiscence and life story activities. This study also noted that younger people shared stories of their experiences with older adults with their families outside of the project. Increased empathy was also found by Gigliotti et al (2005) as week as a study by Schwalbach & Kiernan (2002) which looked at an IG friendly visit programme to a nursing home, involving a class of 22 fourth graders, once a week for five months. However, the Avondale Intergenerational Design Challenge (AVID) by Baker et al (2017) (see above), found no improvements in attitudes towards older adults, empathy or self-esteem in young people. This may have been due to the limited direct face to face contact time the YP had with the residents.

Overall, studies of the impact of IAP on younger people demonstrated improvements in knowledge of dementia, attitudes towards older adults, and increased feelings of comfort. These findings were found across numerous studies despite a range of outcomes and data collection methods used such as questionnaires (Heyman, Gutheil and White-Ryan, 2011; Isaki

and Harmon, 2014), semantic descriptors (Bales et al., 2000), and interviews (Holmes, 2009; Isaki and Harmon,2014).

Care staff (CS)

In this review of sixteen studies only three included findings relating to care staff (Gigliotti et al., 2005; Holmes, 2009; Di Bona, Kennedy & Mountain; 2019). The review of outcomes relating to the impact of IAP on care staff initially intended to look at research that investigated outcomes around care staff and facilitators job satisfaction and attitudes towards dementia. However it became evident evidence on these was limited and there appeared to be a mix of impact on staff, and staff impact on IAP. As a result this section discusses literature of both impact of IAP on staff as well as the impact staff have on the IAP.

For example one study by Gigliotti et al (2005) highlighted both of these forms of impact on IAP and of IAP in relation to the staff involved. The study conducted semi structured interviews with six staff and administrators in order to explore staff perceptions of the effectiveness of IAP, including the associated benefits and costs, and potential sustainability. The study showed that IAP facilitated the development of relationships between staff of all ages, and that good communication, cooperation and team work strengthened the IAP. Having care staff involved in the research increased self-esteem and positive professional development. Practical elements of the processes behind the IAP also emerged such as the intentional nature of partnering up the older adults with the younger people. Furthermore, issues relating to staff turnover and role in the IAP were also raised *'Staff turnover among IG facilitators and support staff created a need for ongoing training and promotion of staff ''buy-in'' to the programme'* and one staff member commented *'There is a real sense in the staff here—and it's ingrained from a long time ago—that sort of their job ends at the door, and they're not really part of anything else that goes on in the building.'* (Gigliotti et al., 2005, p435). This highlights disparities and blurred lines between the attitudes and understanding of a carers role in delivering activities for residents.

Holmes (2009) described the processes behind the planning of the IAP, detailing the input from care staff of the nursing facility, who came together with other facilitator to identify important factors to promote a successful IAP. The team considered potential problems such as administrator, teacher and staff workload, maintenance of required ratios and staff older adult and younger people's insecurities. Through a focus group, staff from both the nursey and older

adult care home shared their experiences and thought around the effectiveness of the programme and indicated that they too had benefited in a number of ways including; enhancing their own knowledge of ageing, receiving support offered to staff morale, increased sense of purpose and being involved in an innovative programme. Whilst these findings offer some insight into the impact of the IAP on staff involved, these results were combined with the experiences and thoughts of older adults therefore disentangling how these themes linked to the different roles remains ambiguous.

The most recent study to explore findings in relation to care staff linked to an IAP in care homes was Di Bona and colleagues (2019). In order to capture a range of opinions on the scheme the Adopt a Care Home study described previously (Di Bona et al, 2019), they included two CH managers, two class teachers and four CH support workers via purposive sampling. This study used questionnaire, non-participant observations, semi structured interviews and focus groups. This study described limited direct impact of the IAP on care staff. One care staff commented that '*…it was really positive for the children, for service users and for the staff…" (Di Bona et al 2019., pg10).* The majority of findings from care staff was in relation to the running of the programme and their perspectives of the impact it had on younger people and older adults. For example, care home staff had positive initial expectations of the scheme and highlighted steps they had taken to ensure its success prior to implementation, such as careful selection of older adult participants, and increasing the number of staff on duty for the first IAP session.

In summary, although some studies have investigated staff perspectives of intergenerational activities, this review identified very few studies that looked at the direct impact the activities may have on care staff and facilitators themselves within care homes. To address this gap in knowledge, this thesis will explore whether intergenerational activities enhance job satisfaction, job empowerment, attitudes towards patients with dementia, and strain and coping within the care sector workforce. Research investigating the effect of intergenerational programmes on all stakeholders, including the impact on job satisfaction and motivation of care staff, may provide impetus to revitalize approaches to social care.

3.3. Effective components of intergenerational activity programmes

More recently, greater emphasis has been placed on reciprocity (Hatton-Yeo & Ohsako, 2000) and fidelity of intergenerational engagement, extending beyond outcome focused research. Researchers have begun curating and collating components of intergenerational practice that are needed to promote positive outcomes. Early studies reported that better quality intergenerational contact (as perceived by the participant), had a greater influence in changing adolescents' attitudes towards older adults as opposed to greater quantities of contact. However, critics have argued that the research failed to adequately distinguish between quantity and quality of contact (Epstein & Boisvert, 2006; Kaplan, 2004) suggesting that despite monitoring of material and activities run, underlying biases were not considered (Epstein & Boisvert, 2006). There are a raft of review/ policy documents outlining good practice in intergenerational practice in order to optimise intergenerational practice (Drury, Abrams, 2017; Duvall & Zint, 2007; Lou & Dai, 2017; Martins et al., 2019; Bryer & Owens, 2019).

When exploring the factors needed for a successful intergenerational programme, Sanchez (2009) differentiated between optional and critical elements. The author deemed four elements as key requirements for an intergenerational programme to exist, including; participants from different generations, a relationship based on resource exchange between participants, planning and management, and the pursuit of participant benefits. In America, Jarrott and colleagues have created a best practice checklist has which can be used to track fidelity of activities 'regardless of the setting'. The checklist comprises 14 best practices, considered to be *'the evidence-based, programmatic 'core components' that enhance the IG experience and outcomes for youth and older adults alike*' (Jarrott, Stremmel, & Naar, 2019) (Table 5).

Table 5

Intergenerational best practices outlined by Jarrott et al (2021)

Intergenerational Best Practices
1. Adult and youth staff members collaborate on IG programming
2. Participants make decisions about IG programming
3. Participants are prepared for and reflect on IG activities
4. IG programme participation is voluntary

5. Activities reflect participants interests and backgrounds
6. Activities are age and role appropriate
7. Activities support mechanisms of friendship
8. Physical environment promotes interaction
9. Social environment promotes interaction
10. Adaptative equipment is used as appropriate
11. Facilitators document and communicate about IG programming

The need for communication between facilitators as well as cooperation and working together was reiterated by (Gigliotti et al., 2005) in relation to the success of a IG summer programme with people with dementia. A subsequent study looked at the TRIP project (transforming relationships through intergenerational programmes) and set out to train facilitators to implement these best practices at two community based sites; a co-located day service where older adults were paired with pre-school age children and a school in which older adult volunteers were recruited from the local community (Juckett, Jarrott, Naar, Scrivano, & Bunger, 2021). Implementation practices were captured over 46 sessions across the two sites and found that distractions were minimised, the activity was documented and the activities were age and role appropriate in all of the session, with a 100% inter-rater agreement. This study also looked at the discrepancy of scores between trained observers and programme leaders and found variation in observations were recorded in relation to whether adaptions to physical space were made, and whether facilitators helped to promote intergenerational interaction sufficiently. They also found that in relation to factors that influenced implementation of the activities, grouping of participants and repeating activities emerged as key themes. Finally they went on to note that real world implementation of intergenerational activities without incentives requires greater commitment from organisations and its staff (Juckett et al., 2021).

Other research has looked at the impact staff training has on the quality of intergenerational programme delivery and engagement, rather than examining the impact on staff (Epstein & Boisvert, 2006). This study found that that staff may only have skills necessary for fit for one generation specifically. Success of intergenerational activities, may rely on the skill development of staff in order to enable meaningful engagement for all participants for example teachers were most competent in working with children, while care staff were most competent in working with older residents.(Cook & Bailey, 2013). Lack of intergenerational training,

something that has been recommended by other researchers to enhance efficacy of intergenerational activities (Weaver et al., 2017). However, limited incentives to carry out these types of activities over and above their already heavy workload is likely to impact upon the ability of care staff to carry out best practices of intergenerational activity programmes.

While this comprehensive list of skills and practical elements might help inform successful practice, Kaplan, Larkin, and Hatton-Yeo (2009) argued that passion - the 'p-factor' – of intergenerational practitioners was the most important component of success for intergenerational practice. Analysis of three case studies demonstrated that the focus is often on the practical skills and knowledge of the facilitators, rather than the characteristics of the facilitators such as values, attitudes and beliefs. The authors argued that the latter had substantial influence over the success of the intergenerational activities and should be considered in greater detail in programmes and activities. Similarly it has been shown that the type of activity impacted less upon the positive outcomes than if the activity was meaningful for participants and supported shared opportunities for relationship building and growth (Galbraith, Larkin, Moorhouse, & Oomen, 2015).

Research exploring the mechanisms that drive outcomes of activity programmes and specifically IAP are much less prominent, with previous research suggesting more work is needed to identify mechanisms which underpin change (George, 2011). A systematic review which examines IAP in the UK did find that 31 of the 43 papers reviewed referenced some examples of best practice. Broad themes identified from this systematic review were sustainability, staffing, participants, activities and transportation, with smaller influencing sub themes found to influence IAP (Table 6).

Although it was highlighted that there were common factors that enhanced best practices in the delivery and implementation of IAP and informed in relation to prior evidence-based practices carried, this review included IAP with community dwelling older adults and a wide variety of studies in terms of what was actually evaluated, and the methods used, with many lacking triangulation of data to other impact outcomes. Sánchez (2007) argued that advancing the field of intergenerational practitioners focus needs to be more on helping practitioners accrue information and knowledge from a range of disciplines within social sciences such as education, psychology and gerontology, instead of curating a new separate knowledge base.

Table 6

Themes identified to influence mechanisms of impact IAP within the UK

Themes	Sub themes
Sustainability	Strategic involvement; Organisational roles; Timetabling; Planning
Staffing	Skills and training; Commitment and enthusiasm; Time and availability; Stability
Activities	Shaped by the participants; Participatory; varied and diverse; focused on developing relationships:
Participants	Preparation; Characteristics of the elderly volunteers; Ensuring mutual benefits
Organisation	Planning; Timetabling; Transportation
Partnerships	Strategic involvement; Operational relations

Despite the proliferation of intergenerational programmes across the UK (Juckett et al., 2021) and best practice guidance it is unclear which factors affect their implementation within the care home environments including OA with cognitive impairments specifically. Furthermore, researchers looking at intergenerational activity programmes often fail to capture and report processes behind the implementation of these programmes (Jarrott, Scrivano, Park, & Mendoza, 2021). As a result it leaves practitioners unable to determine the mechanisms of impact, and how they might go about achieving greatest impact. Care homes in the UK in which staff are constrained by time and resources, can present several different barriers and scenarios which may impact upon the quality of the planning and implementation of intergenerational activities compared to controlled community-based contexts.

3.4. Critique of extant literature

Consistent with scoping review recommendations (Arksey & O'Malley, 2005), the review highlights and reports key study components from the full-text articles (Table 4). It identified gaps in the literature with regards to the types of outcomes measured among older adults, younger people and care staff linked to intergenerational activities in care homes.

Work by Hatton-Yeo and Ohsako (2000) on an international scale highlighted the increasing reported demand for intergenerational programme evaluation, across five different countries. Countries across the world are calling for evaluations that integrate information on the of

effectiveness of intergenerational programmes, with various participant outcomes and use of appropriate conceptual frameworks to help guide such efforts. It has been made clear by intergenerational practice researchers that the number of reliable and valid evaluation and research studies is not keeping pace with the development of intergenerational programmes, especially here in the UK (Canedo-García et al., 2017). In her review of intergenerational practice in the UK, (Granville, 2002) suggests that '*Without further research and evaluation it is not possible to build a conceptual framework that explains in a rigorous fashion whether IP achieves what it claims and if so, why*' (p. 1), supporting previous work by Kuehne and Kaplan (2001) and (Kuehne, 2003).

As intergenerational research field was starting to establish in the UK, reviews of the intergenerational field began to identify the apparent lag between methodological and theoretical rigour compared to the quality and diversity of intergenerational programmes forming across the UK (Kuehne & Kaplan, 2001; Jarrott, 2005). This lag is not seen as surprising, as intergenerational programmes are often values driven, developing organically, as a result, high quality evaluations have been limited in number (Cusicanqui & salmon, 2005; with evaluations left as an afterthought and consequently are often retrospective, and lack baseline of control measures (Femia, Zarit, Blair, Jarrott, Bruno, 2008).

Although intergenerational programmes have seen dramatic progress in the field over the last five years, with increasing interest in co-location and increasing recognition of the social and economic benefits. Springate et al (2008) highlighted that despite diverse outcomes associated with intergenerational activity programmes, it can be difficult to measure or capture many of these in research. In the current economic climate and scarce resources within social care, it is necessary for intergenerational programmes to demonstrate whether they infer positive outcomes and benefits. Robust research looking at IAP in the UK specifically is lacking, with calls for more research demonstrating the wider outcomes of IAP being echoed amongst practitioners (Sommers, 2019). Much of the research to date has failed to disentangle the effects of structured activities on residents in care homes, from the additional (dis)benefits accrued from performing these activities as part of intergenerational exchanges. The majority of studies have been undertaken in North America (Park, 2015; Canedo-García et al 2017), not all have demonstrated benefits (Heyman, Gutheil, White-Ryan, 2011; Middlecamp & Gross, 2002; Biggs & Knox, 2014) and many programmes are of low methodological quality (Low, Russell, McDonald & Kauffman, 2015; Knight, Skouteris, Townsend, Hooley, 2014).

Where systematic reviews are carried out, it appears that it has often not been possible to include 'high quality' outcomes studies, for example Galbraith and colleagues state that '*Due to the limited number of studies on this topic, we were not able to only include high-quality studies, but instead have provided a brief description of the reference type and study design'* (Galbraith et al., 2015) and while Canedo-Garcia's inclusion criteria were *'...large, carefully controlled experimental research study involving hundreds of subjects who are randomly assigned to experimental and control (or comparison) groups*' (Canedo-García et al., 2017), the studies eventually included in their review included those with no control group and with small samples. This was similar case in other review articles, for example Martins and colleagues found that out of the sixteen articles included in their review, only four studies had total sample sizes of one hundred or more (Martins et al., 2019) and a review focusing on documented outcomes for older adults (Lee et al., 2020) .

Further to this, the majority of evaluations are carried out on single sites and/ or single generations, lacking holistic nature, crucial to capturing the broad spectrum of critical success factors and generalisation of outcomes. The intergenerational concept has multidisciplinary roots, for example; demography, education, gerontology, sociology and psychology. The intergenerational concept is also interlinked with numerous social issues relating to individual citizens, volunteers, third sector organisations and local governments. The challenge for intergenerational research is to enhance knowledge and understanding to better meet the needs of all these personal, and better understand the intergenerational processes and best practices. However, much of the evaluation literature in intergenerational work has tended to focus solely on the older adults, and younger people involved. Although recently published toolkit presents a range of validated outcome measures used in intergenerational research for different stakeholders (Jarrott, Juckett, & Naar, 2019) the literature lacks process indicators, leaving a gap in understanding *how* IG programme outcomes are achieved. Many of these studies also fail to give adequate attention to the mechanisms of impact, implementation characteristics (Jarrott, Scrivano, Mendoza & Park, 2020) and the direct impact such activities have on the facilitators; who are often key stakeholders in the planning, delivery implementation of the intergenerational programmes. Table 7 highlights the challenges in the intergenerational research field, and how this research attempted to overcome them.

Table 7

Methods to overcome critique of extant literature

Critique	How this study aims overcomes critique
Evaluation of single sites/programmes	Nine intergenerational activity programmes and seven non intergenerational activity programmes
Lack of baseline measures	Pre and post-test and follow up longitudinal design
Lack of control measures	Use of non-intergenerational care homes as controls
Anecdotal evidence	Quasi experimental mixed methods
Small sample sizes	Large sample size approx. 200 in total
Solely focused on older adults and younger people	Looking at impact of all stakeholders (e.g. care staff)
Evaluation research dominated by USA or Japan research	South Wales focused, therefore more relevant to Welsh policy

3.5. Chapter summary

In summary, chapter three has presented an overview of intergenerational practice literature to date. The initial scoping review highlighted the vast array of formats intergenerational practice can take acknowledging that this is often shaped by the type of setting and context in which they are carried out or delivered. Observations made from this, highlighted the need for a more focused exploration of the literature relating to intergenerational activities carried out in older adult care settings was needed to enable comparisons of findings from this study and its relevant stakeholder groups. The systematic approach used to explore the literature identified a range of outcomes for older adults and young people who had been involved in intergenerational activity programmes, such as improved attitudes towards older adults, and enjoyment from both groups. Closer examination revealed a gap in the literature around the impact intergenerational activity programmes have on care staff within care settings. As well as the need to explore processes that outcomes and enhance the methodological rigour of intergenerational research as highlighted in table 7.

4. Chapter Four - Research Methodology

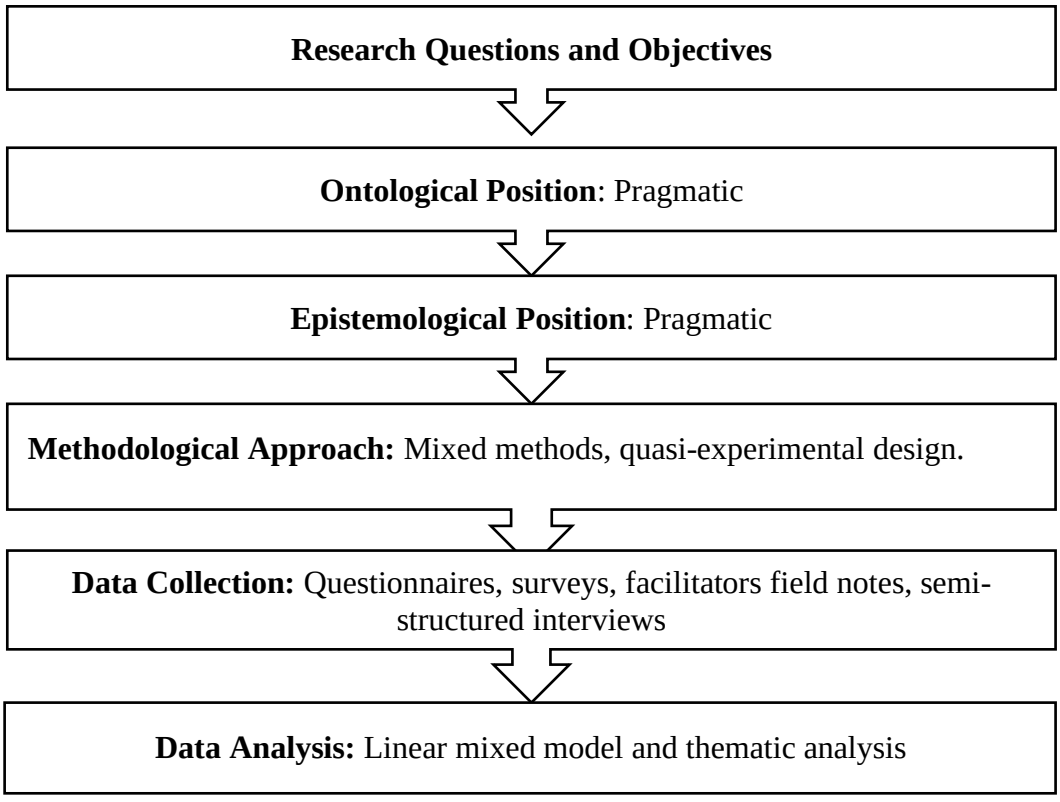
This chapter presents the research methodology. This details the rationale for the methodological research approach utilised in the design, data collection methods and analyses. The research questions and associated research objectives are outlined. The philosophical orientation of the researcher is introduced by outlining and considering some key philosophical paradigms followed by the rationale for adopting a pragmatic approach to this particular research. Both quantitative and qualitative methods are considered, concluding with justification for the use of mixed methods - specifically a concurrent nested approach. The chapter concludes by reflecting upon the quality, validity and reliability of mixed methods and key ethical considerations.

Overview of methodology

This subsection is brief and aims gives the reader a concise overview () of research methodology chapter and research design, before discussion leads onto a comprehensive justification and explanation of the methodology and method.

Figure 3

Outline of methodology chapter structure



4.1. Research Questions

In its broadest sense this research set out to establish whether intergenerational activity can contribute to sustainable provision of social care, change attitudes towards ageing and impact on the wellbeing of residents and care staff. In order to try and answer this overarching question to its fullest the research is built around the overarching research question:

> To what extent if any, can intergenerational programmes change, sustain and catalyse cultures, beliefs, attitudes and behaviours to create age-friendly care home environments?

The research addresses the following sub-questions:

Research Question One (R1) - Can changes in (1) Quality of life of older residents, (2) Attitudes of younger people; (3) Care workers' job satisfaction; and social engagement between these groups be demonstrated through participation in, or involvement with an intergenerational programme delivered in a care home?

Research Question Two (R2) - What are the underlying processes of an effective and socially engaged intergenerational programme that improves connections and communication, promotes meaning and enhances well-being?

Research Question Three (R3) - Can the implementation of intergenerational programmes make a central contribution to sustainable relationship-centred social care and the creation of age-friendly communities in care homes?

4.2. Research Objectives

This research took a 'living lab' approach (van Geenhuizen, 2018) to the research to examine intergenerational activity programmes that have been run in care homes (the living lab) across South Wales. By drawing on interdisciplinary network of long-term care organisations, local authorities, and Health Board collaborations this research was intended to translate evidence-based knowledge in daily practice to provide sustainable solutions for current and future social care provision in residential care for older people. In conjunction with the overarching research question, the long term goals are to draw out implications from the research results that provide recommendations for the future of intergenerational programmes in care homes that take into account multiple stakeholder perspectives. The results of the research may be useful to the

public sector and third sector organisations in terms of prioritising the most effective ways of improving the quality of life and wellbeing older people. The research is one of the first studies to look at intergenerational programmes in relation to the influence they might have on staff morale and job satisfaction. Results could help address at least some of the workforce challenges, generating public debate about future intergenerational shared sites where, for example, crèche or childcare facilities are co-located in care homes. The impact on younger people may also be useful to the educational sector. In particular, the Welsh curriculum will be changed in 2020 and teaching institutions are required to equip young people to cope with new life scenarios (Welsh Government, 2019) such as an increasing ageing population. Having presented a brief descriptive overview of the overall research strategy, the research questions and objectives, the following section of chapter four provides a detailed rationale and explanation of the methodology and methods used in order to answer the three key research questions.

4.3. Philosophical Considerations

Underlying philosophical assumptions held by researchers underpin every research study. This section introduces the philosophical orientation of the thesis, in particular this section will discuss and consider different ontological and epistemological viewpoints and the way the researcher views and experiences the world (Creswell, 2014). The reader will be informed of the overarching philosophical research perspective, which will subsequently inform the following chapters presenting the research design, data collection and analysis of this thesis. Therefore, it is important that these are explicitly acknowledged and understood.

4.3.1. Research Ontology

Simply put ontology is concerned with ‘reality’ and what one determines this as being. Although these thoughts are often implicit in nature, when made explicit they reveal assumptions that influence the research aims, approach, design, data collection and analysis (Tashakkori & Teddlie, 2010). By questioning the existence of facts and objects and what we know about the world, it enables the researcher to reflect on the degree of certainty they can associate to the existence of a ‘real world’ that is independent of their knowledge of it (Marsh & Furlong, 2002, p. 18). For example, is reality considered to be independent of conscience, or does the researcher inform the construction of reality? Two main ontological viewpoints are derived from the answer to these questions, these are objectivism and subjectivism.

Objectivism relates to the existence of a single reality, which can be measured and understood as the 'truth'. It claims that a physical world exists which is independent of the mind (metaphysical), and that scientific claims are true and interpreted literally (semantic) and these scientific truths subsequently constitute knowledge (epistemic). If ontology was depicted along a continuum, *subjectivism* would be positioned most distant from objectivism. Subjectivism relates to the view that there are no absolute truths, instead reality is formulated according to an individual's experience in a particular time and place. This thesis is associate with *subjectivism* which relates to '*contextualised causal understanding'* (Greene et al., 2001, p. 29).

4.3.2. Research Epistemology

While ontology is associated with 'knowledge', epistemology is concerned with what constitutes the acquisition of acceptable and valid forms of knowledge within a certain research discipline (Bell, Bryman, & Harley, 2018). The acquisition of knowledge is key, as it can from the basis of individuals choosing to a form action in response the acquisition of knowledge (Matthews and Ross, 2010). Whilst knowledge is crucial in the social world, most social researchers agree that knowledge is never the ultimate truth due to the complex nature of the social world and the way individuals position themselves within it.

With regards to research, the positioning of the researcher influences the way research is organised, designed, delivered, and interpreted. Researchers associate or align themselves with a particular paradigm, whether this be implicitly or explicitly (Feilzer, 2010). The extent to which researcher associates themselves with particular perspectives can vary substantially with influence from a range of factors such as past experiences, culture and philosophical viewpoints (Tuli, 2010). There are a number of paradigms that are drawn upon in social science research, these are generally referred to as the philosophical assumption or basic beliefs that influence and guide the researchers thinking as to what should be studied, how research should be conducted and subsequent interpretation of results (Bryman, 2004). Each paradigm takes a different stance in terms of ontology, epistemology, and methodology. Other terms such as 'worldview' has been utilised as a synonym for paradigm (Creswell & Clark, 2011). A number of widely acknowledged paradigms exist, these include post-positivism, realism, pragmatism, positivism and interpretivism. Traditionally social science literature has been divided by the latter two, dominant yet opposing paradigms.

During the mono method era, deviations from either of these two dominant paradigms, sparked the so-called 'Paradigm War' (Tashakkori, Teddlie, & Teddlie, 1998) and links back to the wholehearted manner in which paradigms are either fully accepted or fully rejected, leading to frictions and oppositions rather than integration and exchange (Biesta, 2010).

Mixed method researchers have been criticised for the rise in a-paradigmatic approaches to research (Greene, 2007). Tashakkori and Creswell (2006) highlight the difference between mixed methods as the collection and analysis of qualitative and quantitative data compared to the integration of two approaches extending to all aspects of the research process, from the philosophical assumptions, to the interpretation of findings. This draws upon, whether mixed methods approach has been guided by the research question, with researchers required to 'construct' a research design to fit a unique research aim/question or whether a mixed methods approach has been used post hoc to classify research more holistically in terms of the terms of philosophical underpinning. Despite this, many more researchers are acknowledging the benefits of integrating both quantitative and qualitative methods (Whitehead & Schneider, 2013). Consequently, over the past decade mixed methods research has become increasingly accepted as a third methodological movement, alongside purely quantitative and qualitative approaches, particularly within the social sciences literature.

This brings it back to the point of contention in relation to the use of the term paradigm. Some view paradigms as fluid rather than static (Freshwater & Cahill, 2013) and suggest it is possible to depict paradigms on a continuum, with interpretivism at one end and positivism at the other end and realism falling somewhere in the middle (Pawson & Tiley, 1998). A large body of literature supports the view that methodology is driven by philosophical (ontological and epistemological) assumptions (Creswell, 2003; Bryman, 2008) enabling researchers to align such choices with their values, (Mertens, 2012). However some researchers have debated the extent to which this is true, especially in relation to evaluation research (Freshwater & Cahill, 2013; Baker, 2016). Despite significant developments made by 'feminist, postmodernist, poststructuralist, and critical researchers, and many more nuanced positions within these broad frameworks' (Feilzer, 2010, p6), realism, pragmatism, positivism, post-positivism and interpretivism remain dominant within social science epistemological debates and textbooks (Hughes & Sharrock, 2007; Teddlie & Tashakkori, 2009). As a result these positions are discussed in the following section.

4.3.2.1. Interpretivism

Interpretivist approaches are common in social sciences. This paradigm guides researchers to interpret and understand a social phenomenon, with the focus on meaning over measurement (Chowdhury, 2014). Whilst this focus enables deeper insight into the complexities of the social world, meanings and interpretations of the world are subjective and can be viewed from individual or group perspectives, leading to the possibility of the existence of multiple subjective realities (Greener, 2008). Whether multiple realities or a single reality is the better option is open for debate and links back to questions of ontology. This paradigm is inductive and best suited to qualitative research methods in order capture deeper subjective and social elements of meaning (Creswell, 2013). Its social nature and focus on a learner's active construction can be advantageous, although criticism has come from its ability to generate a multitude of interpretations with no ways of evaluating them systematically.

4.3.2.2. Positivism and Post-Positivism

In contrast, *positivists* maintain that knowledge is a matter of cause and effect with facts that can be proven and obtained via direct observable measurement and subsequently reality is the same for everyone (Bryman, 2008). Positivist researchers have argued that in order to predict how one might behave in the future, psychology need only concentrate on things that either positively or negatively reinforced an individual's behaviour, with an individual's thoughts and beliefs deemed unmeasurable and therefore irrelevant (Skinner, 1948).

Realism is the ontological position positivists uphold. Positivists maintain a cause-effect relationship between phenomena, which once established, believe can be used to predicted the future with relative certainty (Rehman & Alharthi, 2016). However, since the middle of the twentieth century, the positivism paradigm has been considered unsuitable, with positivists applying scientific methods to social phenomena (Richards, 2003). Such criticism of positivist approaches leads to a shift towards '*post-positivism'* which spans both positivist and interpretivist paradigms, viewing observation as imperfect and that all theory is revisable.

Post-positivism can be defined broadly to incorporate approaches to knowledge and growth previously rejected by positivism. It acknowledges that individuals are active subjects who are products of their social reality, and not simply the objects of social forces.

4.3.2.3. Pragmatism

Contrary to the *'purists'* who assert paradigms and methods should not be mixed, *pragmatists* believe the choice of approach links directly to the research question's nature and purpose (Creswell 2003). In other words, the most appropriate approach should be utilised to answer the research question whether it be quantitatively, qualitatively, or a combination of the two. Morgan (2007) defines pragmatism as '*systems of beliefs and practices that influence how researchers select both the questions they study and the methods they use to study them'* (p.49). Thus, research questions act as a guide for which methods may be most appropriate to adopt (Shannon-Baker, 2016).

The 'mixing' of competing philosophical foundations, design principles and subsequent interpretation of the two forms of data are the major challenges faced by pragmatic researchers, causing numerous philosophical disputes and debates (Johnson and Onwuegbuzie, 2004; Tashakkori & Teddlie, 2003; Tashakkori and Creswell, 2007). Pragmatists view the world via knowledge gained from personal experience or 'existential reality', suggesting that this can be formed via '*different elements or layers, some objective, some subjective, and some a mixture of the two'* (Feilzer, 2010: p8)

Pragmatism disassociates itself with ontological assumptions of both realism and antirealism. As a result pragmatism has become pertinent in the social science field. Differences between post-positivism and pragmatism lie at an epistemological level. While pragmatists view reality as containing elements that are accessible and independent of the mind much like post positivism, they also acknowledge that reality can be interpreted and renegotiated, with certain elements being socially constructed, thus dependent on the mind. This paradigm is intuitively appealing and the main paradigm utilised by mixed method researchers, with a focus on practical outcomes and a 'what works' stance (Tashakkori & Teddlie 2003b, p. 713).

The argument that views research methods in association with a set of epistemological assumptions has been raised with decreasing frequency in recent time (Bryman, 2008), and we see a shifting focus onto the appropriateness of research methods in terms of best answering the research questions. Pragmatism disassociates itself with ontological assumptions of both realism and antirealism. As a result, pragmatism has become pertinent in the social science field. Differences between post-positivism and pragmatism lie at an epistemological level. While pragmatists view reality as containing elements that are accessible and independent of

the mind much like post positivism. They also acknowledge that reality can be interpreted and renegotiated, with certain elements being socially constructed, thus dependent on the mind. This paradigm is appealing intuitively and is the main paradigm utilised by mixed method researchers with its focus on practical outcomes and a 'what works' stance (Tashakkori & Teddlie, 2003b, p.713).

Further, pragmatists are less concerned with the concept of knowledge and more with the concept of inquiry, in terms of actions and consequences (Morgan, 2007; Shannon-Baker, 2016), allowing for tenets of both objectivity and/or subjectivity (inter-subjectivity) to be explored. This supports the use pluralistic approaches in order to understand the problem fully, enabling epistemological and methodological flexibility (Greene, 2008). Pragmatists view actions as fairly predictable and subsequently individuals build their lives around experiences which link actions to outcomes. A recent paper proposes the use of a pragmatic approach to evaluations, in particular formative process evaluations Evans, Scourfield, and Murphy (2015a). While each of the approaches mentioned so far have advantages in terms of their focus, pragmatism seeks practical and useful insights in order to inform future practice and bridging divides between knowledge and practice (Korte & Mercurio, 2017), which is key in the intergenerational field (Jarrott, 2010). Furthermore, it enables pragmatic choices that recognise real world constraints in relation to time and resource limitations. As a result a pragmatic point of view was utilised throughout this thesis, with the view that *'knowledge exists in the form of statements or theories which are best seen as instruments or tools; coping mechanisms, not once-and-for-all-time truths*' (Bryant, 2009, p4).

4.4. Methodological Approach

The research approach and analyses were guided by the need to comprehensively explore the impact intergenerational programmes being run in care homes across South Wales are having on those connected to the programmes. This section aims to outline the premise of the mixed methods and evaluative approaches used in order to answers the research aims and objectives. The first section discusses the practical implications of quantitative and qualitative approaches and how they might be best used for this research, when integrated within a mixed method approach. Discussion then leads into the importance and often under-valued type of research; evaluation

4.4.1. Quantitative Methods

Quantitative research is often deductive in nature, involving the collection of numerical data in order to produce statistical data. These data are used with the intention of either accepting or rejecting a predetermined hypothesis and are used commonly within medical and psychological sciences. Using quantitative methods enables quick and precise evaluation of a number of specific variables with a large sample size, facilitating group comparisons and the strength of association between such variables. In this thesis, the use of these quantitative methods was determined by three factors:

1. The ability to gather large amounts of data to inform greater generalisability
2. To enable efficient impact evaluation across different time points
3. To infer the magnitude of correlational effects between variables

Quantitative data collection consisted of standardised questionnaires. Questionnaires were chosen as the most appropriate and versatile way to capture a number of different impact outcomes across a broad range of participants, and thus providing useful comparable data. This enabled comparison of scores in each of the questionnaires at a number of different time points, providing suitable points for comparison across time. Each questionnaire comprised of reliably and validated standardised measurement scales used to assess different impact outcomes. Each of these measures are discussed in further detail in section 5.4.1. When designing the questionnaires consideration was given to the resources available to the researcher these included funding, time necessary for researcher and participants for example whether questionnaires were going to be administered face to face or via self-completion, response rate, accessibility of target participant groups, age and literacy level of respondents, as well as.

The quantitative approach is advantageous in determining specific impact outcomes that intergenerational activities might have on the participants involved. However, it is important to understand these outcomes within the culture or context (Sánchez, 2009), in the case of this study; care home culture. Relying on purely quantitative outcome alone risks omitting the important role 'context' and 'individual experience' plays in relation to outcomes of intergenerational activity programmes, this is referred to as decontextualization (Viruel-Fuentes, 2007). Unless the original socio-ecological processes are explored, *'a holistic understanding of the way that particular groups and systems function'* (Ward, 1999, p. 10) remains evaluation remains incomplete. Quantitative methods alone mute the expressive nature

of participants as social agents (Sánchez, 2009) limit the interpretation of the outcomes. Therefore, it was deemed necessary to also consider qualitative methods.

4.4.2. Qualitative Methods

Qualitative research methods are typically exploratory in nature and concerned with participant recollection and experiences. These tend to be highly subjective and include participants understandings, opinions, feelings and beliefs (Creswell, 2007; Keele, 2011; Plano Clark & Creswell, 2008). This facilitates the interpretation of the different meanings certain groups or individuals assign to certain events or situations. The complex nature of a social phenomenon such as intergenerational activity programmes lends itself well to qualitative research, with its ability to obtain detailed contextual information about the views, perceptions and actions of different individuals. For this study, in depth, semi structured interviews were chosen in order to achieve such biographical insights, and in order to capture viewpoint of three different participant stakeholder groups. This decision was also influenced by the phenomenological epistemological position, enabling insight into what works, for who and in what circumstances.

In this thesis some of the shortcomings of using purely quantitative approaches alone are addressed by including *semi structured interviews* and inclusion of *open-ended questionnaires*. In depth, semi-structured interviews use a schematic presentation of questions or topics that the researcher wishes to explore. These set a fairly systematic dialect for the interview, whilst generating a comprehensive picture of phenomena under investigation, by allowing expansion of certain topic areas. Studies focusing on intergenerational activity programmes have tended to utilise qualitative approaches in favour of quantitative approaches (Jarrott, 2011; Knight, Skouteris, Townsend, & Hooley, 2014). This may be a result of the time-consuming nature of collecting data from large sample sizes, both pre and post programme implementation. Focus groups, enable the collection of larger quantities of qualitative data from a range of participants who have shared similar experiences (Milena, Dainora, & Alin, 2008). However, in this study focus groups may have hindered the level of detail and honesty about how a participant they truly felt about the activities. The aim of the qualitative element in this thesis was to elicit personal accounts and individual experiences of the activities. Jarrott (2011) also suggested that the high prevalence of studies using purely qualitative data may reflect an increasing acceptance of qualitative research as a rigorous and appropriate method of understanding an intervention when standardized measures do not exist. Despite this, Jarrott still refers to the use

of mixed methods as the desired approach, allowing triangulation of data in order to enhance interpretation of outcomes.

4.4.3. Mixed Methods Research

Much like epistemology, and interpretivist and positivist paradigms, research methods are dominated by two main approaches: qualitative methods that are associated with interpretivist approaches and quantitative methods that are associated with positivist approaches. Mixed methods are a hybrid of both methods (Tashakkori & Teddlie, 2003). This research utilises a mixed methods approach combining both approaches. The next section discusses the strengths and possible contention faced by researcher adopting a mixed methods approach. As mentioned in the above sections 4.6.1. and 4.6.2., when used in isolation qualitative and quantitative approaches have both positive and negative features. As a result of the potential drawbacks with each approach, popularity of mixed method research has grown substantially over the last two decades, giving rise to a so called third research community (Teddilie and Tashakkori, 2010). A concrete definition of mixed methods research has been offered by Tashakkori and Creswell, 'Research in which the investigator collects and analyses data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study of a programme of inquiry' (2007, p 4).

It has been argued that mixed method approaches to research bridge the disparities between quantitative and qualitative methods, by compensating for apparent weaknesses, complimenting certain strengths and enriching possible interpretations (Brewer & Hunter, 2006; Bryman, 2006; Park, 2015). For example, a study looking at an intergenerational visitation programme was able to draw upon quantitative analyses as well as observational data in order to highlight discrepancies between the written responses recorded by children, and real time behaviours witnessed by care staff (Marcia et al., 2004). The ability to minimise discrepancies in data is just one of the factors that has led to mixed method evaluations gaining a significant reputation in enhancing the creditability of the evaluation findings within health and social care settings (Bamberger, 2012; Hall, 2013; Happ, Dabbs, Tate, Hricik, & Erlen, 2006) and in NHS intervention evaluations (Maben, Penfold, Glenn, & Griffiths, 2012).

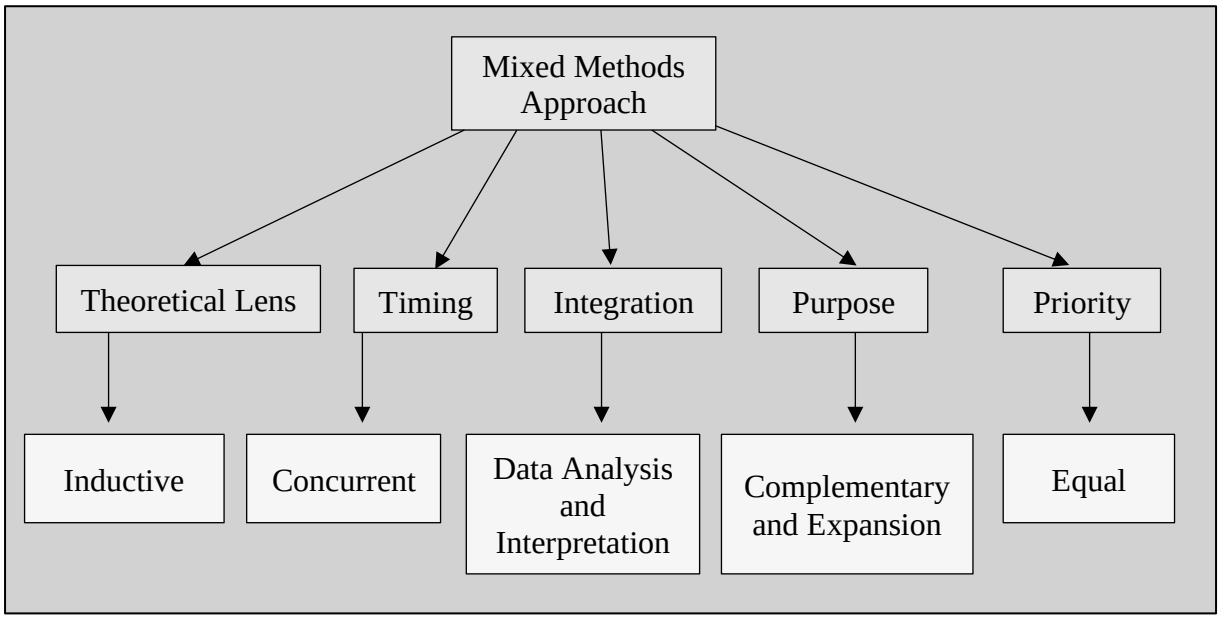
In complex intervention studies such as this, a mixed methods approach was as considered most appropriate (National Institute of Health Research School for Social Care Research, 2013; Yin, 2009). Methods were chosen pragmatically, to capture as many activity programmes as

possibly, whilst achieving an optimal balance between high quality data and as little disturbance and burden for those participating in and delivering the activity programmes. Previous evaluative research in the intergenerational field has highlighted the significance of utilising a 'multi-pronged approach' when gathering data (Hayes, 2003)

Mixed methods research enables a more thorough and complete understanding of the topic under consideration than would have been possible by using either purely quantitative or qualitative approach alone (Creswell & Plano Clark, 2011). This is often recognised as one of the key purposes to implement such a design. Whilst purpose is often a key motive for undertaking mixed method research, there are also four other key dimensions that should be considered which include; theoretical lens, timing, point of integration, and priority (Clark & Creswell, 2008; Schoonenboom & Johnson, 2017). In relation to this thesis, Figure 4**Error! Reference source not found.** highlights the type of approach taken in relation to each of these five dimensions in this thesis.

Figure 4

Key dimensions on the thesis' mixed methods approach



These aspects of the mixed methods approach taken in this research intend to guide and compliment the pragmatic research perspective described at the start of this chapter and are discussed in more detail here.

Theoretical Lens: *Inductive*

The intergenerational field highlights a range of potential outcomes associated with intergenerational activity programme, however practice has been Iterative and evolutionary with a practice based approach as opposed theoretical foundations guiding practice. This is reflected in the inductive this mixed method approach used in this study. It intends to use robust research methods, to explore suggested causal links between intergenerational activity programmes and potential benefits to various stakeholders in different care home settings across South Wales. Findings will be used to inform future theory around IAP and evidence based practice.

Timing: *Concurrent*

There are two forms of mixed methods approach; sequential, where qualitative data is collected before quantitative data or vice versa, and concurrent in which quantitative and qualitative data are collected simultaneously. Concurrent methods were used for this research. Creswell and colleagues (2003) identified three types of concurrent designs (i) concurrent triangulation, (ii) concurrent nested and (iii) concurrent transformative. This thesis utilises a concurrent triangulated mixed method design, where both quantitative and qualitative data are collected concurrently, and priority is equal between the two approaches Morse (2003).

Integration: *Data analysis and Interpretation*

The quantitative and qualitative data from questionnaire responses, open ended feedback about the experiences of the activities through semi structured interviews and facilitator field notes which contained staff observations are triangulated after it was collected.

Purpose: *Complementary and Expansion*

Integration was used to enhance the validity of the findings from this study. Due to the complex nature of care environments and several different influencing factors, triangulation builds a '*more in-depth picture of a research problem, and to interrogate different ways of understanding a research problem.'* (Nightingale, 2020, p. 477)

Priority: *Equal*

This relates to the type of data that will be given greater priority. In this thesis, both quantitative and qualitative took equal priority in terms of findings and answering the research questions.

Table 8 provides a breakdown of the different data collection methods and analytical procedures used within both the process and summative evaluations to capture the different elements of the intergenerational activity programme and non-intergeneration activity programme.

Table 8

Break down of mixed methods used for different elements of the research

Issues Guiding Evaluation	Methods Used	Data collection techniques
Pre-post changes over times	Psychometric Analysis	Questionnaires
Subjective Issues	Thematic Analysis	Semi Structured Interviews Intervention feedback questionnaire
Context and Implementation	Thematic Analysis	Field Notes (researcher) Field note booklet (facilitators)

4.4.4. Quasi-Experimental Design

In line with a pragmatic point of view, Silverman (2011) suggests that the research question should influence the choice of research design. However, Yin (2009) suggests there is more to the choice of design than the research question, for example he proposed that the research strategy should be influenced by three factors, 1). How much control the researcher has over the particular behaviour 2). The degree to which historical and contemporary events are focused upon and 3). The type of research question.

Whilst experimental designs are favourable when analysing the causal relations between different factors, enhancing internal validity by minimising the effect of other variables, they are often difficult to achieve, due to the need to mimic a real-life context in often unrealistic surroundings. This can lead to over-simplification of the experimental conditions, hindering generalisability to the 'real world' and subsequently the research's external validity. To ensure validity and identify whether an intervention has had the desired, the research utilises a longitudinal quasi experimental design, in which two settings were compared: one delivering

intergenerational activities and one delivering non-intergenerational activities. Care homes are complex environments; changes in outcomes for individuals can be the result of many different factors; engagement in meaningful activities could be just one. It is therefore important to use comparison sites to control for variables unrelated to the intergenerational programmes in order to isolate impacts attributable to the intervention. By comparing the intervention with an active control intervention, the impact of taking part in activities specifically would be controlled for. The advantage of using this approach is that it utilises time and resources efficiently: a solo researcher can obtain large quantities of data with limited resources. This method could help build a detailed picture of the participants experiences associate with intergenerational activities (Bergman, 2008) maximising time and resources available, but would also assist in the generational of the results .

A key criticism of quasi experimental designs is that, unlike randomised control trials, they lack a key component of random assignment. Potentially, differences in key characteristics between the two groups may be responsible for outcomes, rather than the IAP. A randomised control trial (RCT) was not logistically feasible, as resources and funding which would have been required to run each intervention were beyond the realm of this study. Further to this, the researcher had no control over the interventions with targeted programmes delivered independently of the research. A recent review of intergenerational programmes (Gualano et al., 2018) found only one randomised control trial which demonstrated a low risk of bias. Furthermore, although most studies used a pre and post research design, many lacked comparisons via a control group. In order to overcome common critiques of quasi experimental deigns and enhance internal validity of the findings, in this current study, it was decided that residents in the 'non-intergenerational organized activities' group would be matched to residents in the 'intergenerational activities' group.

4.4.5. Synthesis of Qualitative and Quantitative data

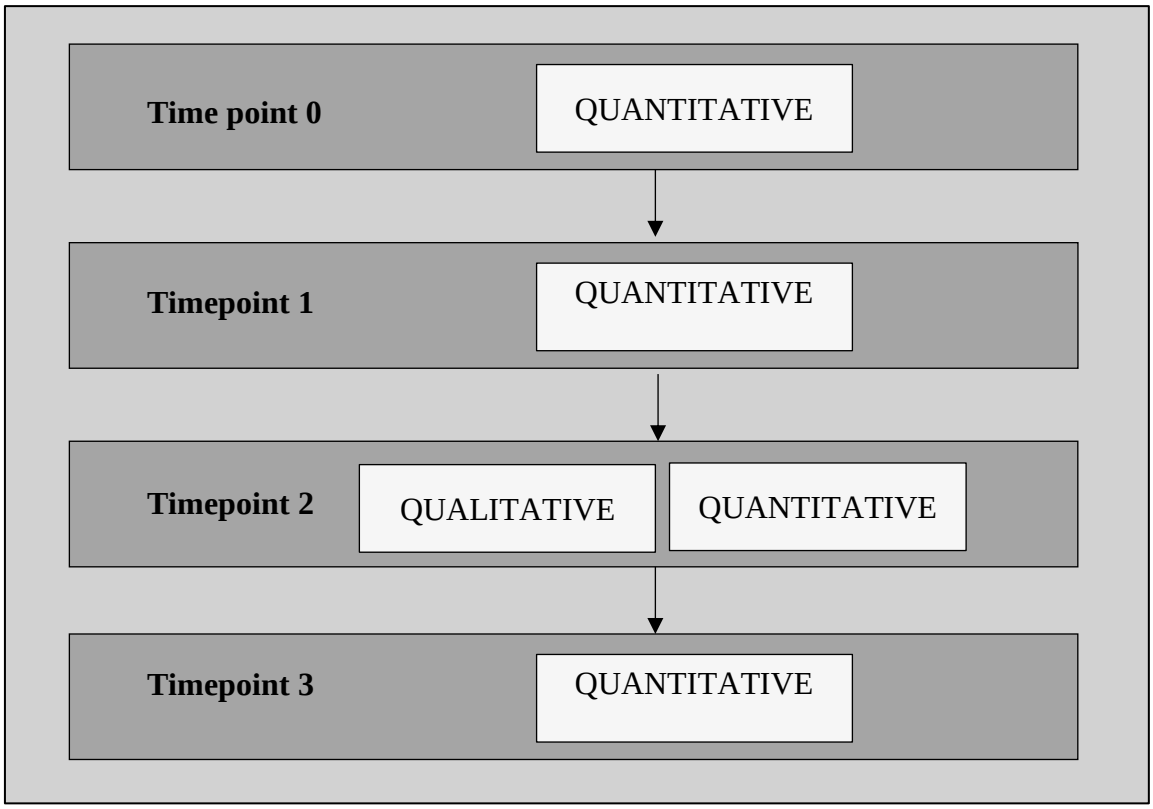
This study combines both quantitative and qualitative data collection method by using a concurrent triangulated design, with four phases (Creswell, Fetters, & Plano, Clark, 2005). This approach provides greater validity, understanding and convergence of findings. The qualitative element facilitates more enriched data by capturing individuals personal experience, challenges, opportunities of the different activities, allowing for elaboration and/or elucidate upon specific

'in the moment' behaviour, stories and recollections which otherwise would not be captured by purely quantitative data alone (Creswell, Clark, Gutmann & Hanson, 2008).

Further to this, in-depth exploration of personal stories are impactful at a micro level, and can be used to help consider the broader community effects at meso and macro levels. Therefore, the approach would be relevant to enable evaluation of the contribution intergenerational activities may have both at an individual level and more broadly in creating age friendly care home communities. Finally, the approach was well suited to pre and post intervention analysis (Creswell, Clark, Gutmann, & Hanson, 2003), including initial screening and a longitudinal follow up. In addition to this, and more specifically within the intergenerational literature, it has been recommended that evaluations of intergenerational programmes should extend beyond the programmes themselves (Canedo-García et al., 2017; Jarrott, 2011; Sánchez, 2009).

Figure 5

Four phase concurrent triangulated design



4.4.6. Quality, validity and reliability in mixed methods

Mixed method have some weaknesses. In terms of sample sizes, mixed methods research draws upon a broader integrative perspective in order to determine an appropriate sample size. Mixed methods researchers must find a balance between both smaller qualitative sample sizes (e.g. 10-40 participants) in order to conduct more in depth analyses with larger quantitative sample sizes that can enable reliable multivariate statistical analyses (Yoshikawa, Weisner, Kalil, & Way, 2008). Triangulation is a key factor in enhancing a studies validity and reliability (Victor, Westerhof, & Bond, 2007). Extracting data from a variety of sources enables the researcher to identify conflict or corroboration, providing greater depth and breadth of understanding the phenomena. Using different data collection procedures and obtaining information through a number of different participants provides good grounds for strengthening the validity and reliability of a study and has been encouraged by other researchers in the field when looking at 'a complex relational phenomenon such as intergenerational volunteering' (George, 2011, p. 395). In this research, the use of questionnaires, surveys, in depth semi structured interviews and summary booklets amongst four different stakeholder groups, lends itself well to a robust approach to data collection (Zohrabi, 2013).

4.4.7. Evaluation Research

Recent political uncertainty and austerity have created environments where competition for resources in health and social care sectors is becoming increasingly fraught, with demand increasing in line with the growing proportion of older adults and money for resources is dwindling. As a result, the collaborative delivery of services and the sharing of resources is becoming more and more crucial, and especially valuable to policy makers. Evaluation of intergenerational activities programmes are in great demand but are often an afterthought. Evaluating and demonstrating the wider successes or failures of interventions within such settings is more crucial than ever. Whilst there are some perceived tensions between quantitative and qualitative methodological approaches and outcomes that often accompany evaluations of interventions, pragmatism shifts away from philosophical principles and is more orientated towards the appropriateness of the research methods used. Evaluative research lends itself well to applied research and can lead to practical and real-world applications. This approach requires a systematic and rigorous process in order to extract meaningful insights (Rossi, Lipsey, & Henry, 2018), which in relation to this thesis is to inform policy and future

delivery of intergenerational activity programmes. There are two main forms of evaluation research that have been utilised within the intergenerational evaluation literature; summative and process evaluations (Mariano Sánchez, 2009), This research looks to bring these two forms of evaluation and subsequent findings together to triangulate and generate a holistic insight into IAP practices.

Summative Evaluation

Summative evaluations demonstrate the effects and/or impact brought about by a programme or initiative in a certain social setting; these can be intended or unintended outcomes. Whilst most social programmes have good intentions, that are intuitively plausible, this does not mean that they automatically lead to beneficial outcomes, unintended outcomes should also be examined and explored. Reliable quantitative outcomes of IAP are lacking (Bernard and Ellis, 2004). The programme under evaluation is conceptualised as the specific cause for outcomes or effects as it is implemented. However, it is important for researchers to consider the independent variables which determine the success or failure of such programmes. To do so, exploring the processes involved in delivering the program is key.

Process Evaluation

Research has shown that in order to build an evidence base that informs policy and practice, evaluation of the causal assumptions that underpin an intervention is vital (Moore et al., 2015, p. 1). The process evaluation was used to guide the selection of research methods, by breaking down each component of the process required to evaluate the intervention and searching for the most appropriate method to capture these given limited resources and time of the researcher. The process evaluation in this study uses a mixed method approach, which draws upon qualitative semi structured interviews, facilitator field notes, and intervention feedback questionnaires. Understanding of the causal assumptions underpinning an intervention and use of evaluation to understand how interventions work in practice are vital in building an evidence base that informs policy and practice (Craig, Dieppe, Macintyre, Michie, Nazareth & Petticrew, 2008).

Process evaluations are particularly useful in interventions that have many components or with interventions with multiple potential outcomes and complexities (Evans, Scourfield, & Murphy, 2015; Moore et al., 2015). Interventions can be considered complex for a number of reasons, this intervention was considered complex due to the number of groups and settings, and the

level of flexibility given to the individuals implementing the intervention (Skivington, Matthews, Simpson, Craig, Baird, Blazeby & Moore, 2021).

There are various process evaluation frameworks (Moore et al., 2015; Saunders, Evans, & Joshi, 2005; Young & Sharpe, 2016). The process evaluation in the present study is adapted from the MRC guidance framework for conducting and reporting process evaluations (Moore et al., 2015) in order to best answer the research questions. This framework builds on the process evaluation themes described in the 2008 MRC complex interventions guidance (Craig, Dieppe, Macintyre, Michie, Nazareth, & Petticrew, 2008), with Moore and colleagues outlining key recommendations when analysing the process evaluation:

- Provide descriptive quantitative information on fidelity, dose, and reach
- Integrate quantitative process data into outcomes datasets to examine whether effects differ by implementation or prespecified contextual moderators, and test hypothesised mediators
- Ensure that quantitative and qualitative analyses build upon one another (eg, qualitative data used to explain quantitative findings or quantitative data used to test hypotheses generated by qualitative data)
- Where possible, initially analyse and report process data before trial outcomes are known to avoid biased interpretation
- Transparently report whether process data are being used to generate hypotheses (analysis blind to trial outcomes), or for post-hoc explanation (analysis after trial outcomes are known)

In line with these recommendations, the researcher tried to adhere to these as much as possible given the limited time and resources available, with five key domains emerging as areas for the researcher to focus the process evaluation. This is highlighted in table 9 which has been adapted from the work by Moore, Audrey, Barker, Bond, Bonell, Hardeman, & Baird (2015) and Saunders, Evans & Joshi (2006).

The MRC framework refers to more clinically used terms such as dose, reach and fidelity. In this study the dose delivered referred to the number of session run, dose received referred to the number of sessions attended by participants, reach referred to the participation rate and explanation for participation and non- participation and finally fidelity referred to the quality and extent to which the programmes were delivered as planned. These were selected by the

researcher to help capture the approaches to development and delivery for each type of intergenerational activity and non-intergenerational activity.

Table 9

Process evaluation components, related questions and data sources

Components		Definition	Data Sources
Context and content		How were sessions planned? Where were the sessions run? What environmental or social factors influenced the activity programme implementation or outcomes?	Semi structured interviews, intervention feedback questionnaire and facilitator field notes
Implementation			
	Dose delivered	What proportion of the intended intervention was actually delivered to the intended audience?	Semi structured interviews, intervention feedback questionnaire and facilitator field notes
	Reach	How were participants approached to participate in the activity programme? Participation rates and explanation for participation and non- participation (Facilitators and barriers to participation)	Semi structured interviews and facilitator field notes (Attendance records)
	Fidelity	The quality of the implementation of an intervention	Semi structured interviews, intervention feedback questionnaire and facilitator field notes
Mechanisms of impact		Participants responses to and interactions with the activity programme, as well as unexpected consequences	Semi structured interviews, intervention feedback questionnaire and facilitator field notes

Context and content: This element of the process evaluation enables exploration of the wider contextual influences that might affect the activity programmes, whether it be direct and indirectly. The process evaluation is concerned with the how and why of interventions therefore this element plays a key role in helping identify key influencing factors.

Implementation: Identifies ways in which the participants were approach to take part in the activities, what was used to inform them that the activities were being run. This section also includes aspects of the activity programme such as dose delivered, which related to the whether the intended number of programme components were delivered as planned, the actual, and how many participants took part or were involved. Fidelity relates to where the intervention overall was delivered as they had set out to, and the quality of the programmes components that were delivered.

Mechanism of impact: This allows exploration of the extent to which the intervention activities have been implemented as intended and determine programme reach and help to better understand the relationship between the components of the activity programmes and offer further explanations for any effects observed, and thus the interpretation of outcomes (Linnan & Steckler, 2002; Moore et al., 2015). This helps to understand the advantages and disadvantages of activity programme variations, and gather information relating to barriers and facilitators to successful implementation and delivery of such activities, enabling the researcher to present key recommendations and aspects needed to support implementation and sustainability of meaningful activity programmes (Tiffany Young & Chantelle Sharpe, 2016).

Overall the summative and process evaluations enable the researcher to more fully understand the impact the activity programmes had on the participants, their views on practical elements of the activity programmes as well as personal subjective experiences of the interventions.

4.4.8. Reflexivity

Qualitative methods have been criticised as they can be open to varying degrees of subjectivity. Therefore, reflexivity is an important part of the evaluation process and ensuring research bias is minimised, especially when conducting qualitative research methods. For example the 'Hawthorne effect' suggests that interviewees may alter their behaviour to fit what they '*think*' is the right thing to say or do (Sedgwick & Greenwood, 2015). Sandelowski and Barroso (2002)

address the different aspects of reflexivity in relation to one's inward and outward points of view. They explain that 'reflexivity implies the ability to reflect inward toward oneself as an inquirer; outward to the cultural, historical, linguistic, political, and other forces that shape everything about inquiry; and, in between researcher and participant to the social interaction they share *(*Sandelowski and Barroso, 2002, p. 222). Therefore it is important to be reflexive and reflective in relation to both the individual researcher and the participants, in order to consider any influence this may have had in the conducting and reporting of this research (Creswell, 2014). This is something the researcher was conscious of throughout the course of this research. The researcher had no input into the design or delivery of the intergenerational activity. The researchers role was to evaluate practice that was happening regardless of the research being carried out.

4.5. Chapter Summary

To summarise, this chapter has introduced where the researcher sits in terms of their epistemological and ontological stance and how this has been drawn upon to identify the best use of methodological approaches to answer the three key research questions. Through this process, mixed methods were identified as being most appropriate, with the strengths and weaknesses of this approach discussed in detail

5. Chapter Five - Research Methods

Previous chapters explained the overarching theoretical perspectives and methodological approach adopted for this study. This chapter initially provides a brief overview of the five phase methodological framework before providing greater detail of each phase. This chapter provides the specific information about the sampling strategy and recruitment processes including research sites, research participants and the data collection processes for both quantitative and qualitative methods. The chapter concludes with data analysis techniques used to produce the findings presented in the chapter six.

The research explored the impact of running intergenerational activity programmes compared to non-intergenerational activity programmes delivered in different care home settings in South Wales. Care homes providing non-intergenerational activity programmes acted as an active control. The research took a "living lab" approach in order to capture real life context, without altering current practices. All activity programmes would have occurred regardless of the research taking place. The research was conducted over a year from January 2020 to January 2021 and used a repeated-measures within-subject design to generate summative and process evaluations via the collection of quantitative and qualitative data across five phases. These five phases of the research included: 1. Screening (T0), 2. Pre-Intervention (Baseline. T1), 3. Intervention, 4. Post-intervention (T2), 5. Longitudinal follow up data collection (T3). An overview of the research design is presented in a summarised format (See Figure 7) and will now be discussed in greater detail.

5.1 Research Sites

This research focuses specifically on intergenerational and non-intergenerational activity programmes within the care home context. Care homes included both residential and nursing care homes. Residential care homes are settings which provide 24-hour support for older adults in terms of accommodation, meals, and personal care. Nursing care homes provide 24-hour support for older adults in terms of accommodation, meals, and personal care, but with the additional supervision from onsite registered nurses. Nursing homes often support residents with more complex (health) needs. Some care homes offer both residential and nursing care places, and these were also included in the selection process. Private, charity, or council run care homes were all eligible for selection. Including both residential and nursing settings

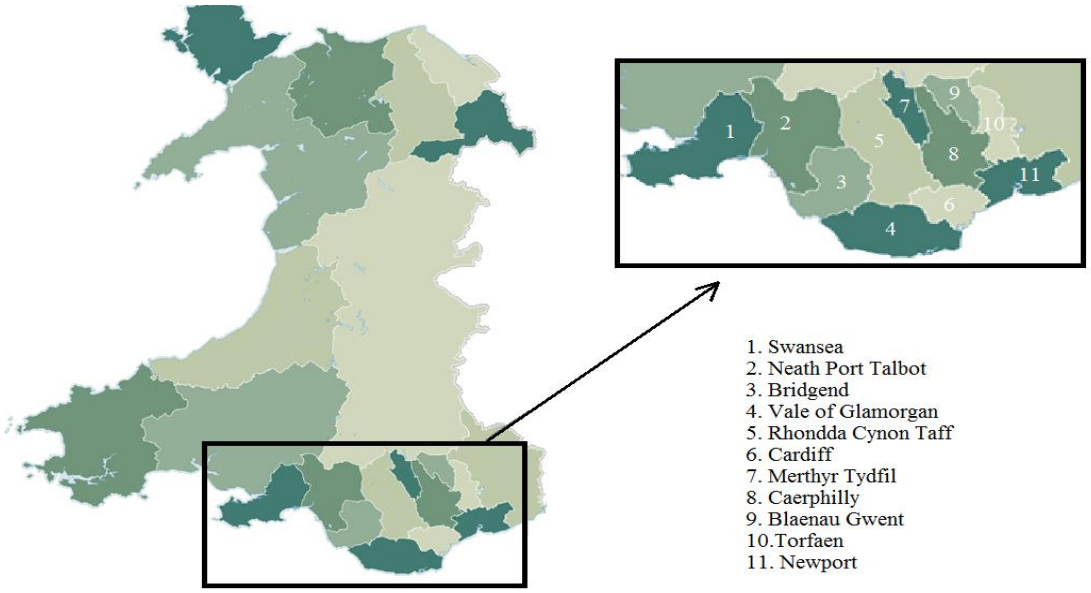
provided variability in terms of settings and recruitment but confined the variation in context to a manageable level within the capacity of this thesis and generalisability of the findings.

5.1.1 Care Home Sampling Strategy

The geographical location of the study area was constrained by time and financial resources. As a result, the first level of sampling for care homes used a pragmatic cluster sampling strategy, with selected counties accessible within a reasonable travelling distance (of Swansea University). Residential and nursing care homes providing non-intergenerational and intergenerational activity programmes from the eleven counties across South Wales were invited to take part in this study. These include: Swansea, Neath-Port Talbot, Bridgend, Vale of Glamorgan, Rhondda Cynon Taf, Cardiff, Merthyr Tydfil, Caerphilly, Blauneu Gwent, Torfaen and Newport (Figure 6).

Figure 6

Map of eleven selected counties in Wales



While generational labelling is recognised as being useful, the failure to identify the variation and different levels of area disadvantage that exist within communities, such as regional variations within the UK has been recognised (Keating et al., 2015; Marmot et al., 2010). It is something that was considered when looking at the settings in which the activity programmes were carried out (See Table 10).

Table 10

Detailed information about study areas by county

	Average population	Percentage of YP (%)	Percentages of OA (65+) (%)	% (LSOA) in most deprived 10%
Cardiff	362,756	**18**	14	18.2
Swansea	245,480	17	**19**	11.5
Rhondda Cynon Taff	239,127	**18**	**19**	17.5
Caerphilly	180,795	**19**	**19**	10.0
Newport	151,485	**20**	17	24.2
Bridgend	144,288	**20**	**20**	6.8
Neath/Port Talbot	142,090	17	**20**	15.4
Vale of Glamorgan	130,690	18	**20**	3.8
Torfaen	92,264	18	**20**	5.0
Blaenau Gwent	69,609	17	**20**	12.8
Merthyr Tydfil	59,953	**19**	19	22.2

Note. *LSOA stands for Lower layer super output areas*

5.1.2 Care home inclusions and exclusion criteria

The inclusion and exclusion criteria for the care homes are outlined in Table 11. One of the key exclusion criteria for the intervention sites if that they were currently running a structured IAP or had run a structured IAP within the past 6 months. Care homes that had previously run ad hoc, or one-off occasions where children came into the care home (e.g. to sing or for Christmas parties) were not excluded from the study.

Table 11

Inclusion and exclusion criteria for the care homes (CH) included in the study

	Inclusion Criteria	Exclusion Criteria
Intervention sites: IG	- CH located within the selected counties - CH running an IAP at least once a week for eight weeks - CH running IAP with younger people between the age of 5-18 years of age and residents over the age of 65 - The IAP must involve at least three residents who have the capacity to provide informed consent. - Programmes starting between January 2019 and December 2020 - CH with minimum of three residents engaging in activities who were able to provide informed consent	- Sheltered or supported living sites that were not registered as residential or nursing homes - CH that have already run a structured IAP in the past 6 months or are currently running one
Active Control Sites : Non-IG	- CH running a regular structured AP at least once a week for eight weeks - Programme involves at least three residents who have the capacity to provide informed consent. - Programmes starting between January 2019 and December 2020 - CH with minimum of three residents engaging in activities who were able to provide informed consent.	- Sheltered or supported living sites that were not registered as residential or nursing homes - CH that did not provide any form of regular AP - CH with three residents engaging in activities who were able to provide informed consent.

5.1.3 Care Homes Recruitment

Initially, the researcher emailed key organisations that had links to care homes across South Wales, with the aim of identifying care homes interested in taking part in research or looking to set up an intergenerational programme. The researcher worked with a number of partners to help with the recruitment of care homes to the study. A key partner was the Enabling Research in Care Homes network (ENRICH Cymru) hosted by Swansea University. The ENRICH network is a network of research ready care home across Wales that are interested in being involved or informed about research projects. Working with ENRICH helped focus the researchers search for relevant care homes, with ENRICH facilitating initial contact between the researcher and the care home manager. Ffrind I Mi a befriending service in south Wales who launched the intergenerational strategy and have a particular interest in intergenerational practice were another key organisation the researcher connected with. Individuals leading the Ffrind I Mi scheme had connections and knowledge of intergenerational partnerships happening in the Gwent region of South Wales. They also helped provide links to the digital heroes project through digital communities Wales (Digital Communtities Wales, 2021).

Other collaborators included Hen Blant Bach, Linc Cymru, Mind Newport, and the CIA (Centre for Innovative Ageing) networks. Through links with relevant individuls in these organsations, the researcher was able to disseminate her calls for care homes about to embark on an intergnerational programme. These organisations also provided care home contact details and valuable background information about which homes were intending to run intergenerational programmes. As a result, this second level of sampling was a purposeful sample of care homes in the selected counties identified in the first level of sampling.

In addition to the help from partners, other recruitment strategies were used. These included direct emails to care home managers, adverts in partners' newsletters, and flyers for use on social media platforms such as Twitter, which provided greater reach to other organisations such as schools and third sector organisations looking to start intergenerational activities. The sampling strategy also benefited from a snowballing effect with word of mouth between care home managers within the same organisations, as they had good insight and knowledge as to what other care homes were providing in terms of their activity programmes. Initially the researcher set out to recruit ten care homes in each setting; intervention and active control setting, but lack of responses from care homes and limited time and resources meant this was

not possible. Instead, nine were recruited in the intergenerational setting and seven were recruited for the non-intergenerational setting.

Once potential care homes were identified contact was made with the care home managers via email or telephone. Emails included all the necessary information sheets about what they could expect from taking part in the study (See appendix 2). Leads were followed up with subsequent emails and face to face meetings with organisation managers to build rapport, explain more about the purpose of the research, and ensure that the non-intergenerational activity programme or planned intergenerational activity programme would meet the inclusion criteria. By visiting the care homes several times prior to data collection, the researcher also met other members of staff and become familiar with the care home and its residents.

5.1.4 Profile of Selected Counties and Care Homes

Overall, twenty-five care homes were approached to take part in the study. These varied in size, ownership, location (including level or area of deprivation), and service provision (e.g residential or nursing care). Out of this twenty-five, nine care homes either chose not to participate or did not respond to initial contact made by the researcher. As a result of this, a total of sixteen care homes met the inclusion criteria and agreed to participate: nine care homes running an intergenerational activity programme and seven care homes providing non-intergenerational activity programmes. Table 12 presents details of each care home's characteristics.

Table 12

Characteristics of care homes

Setting	Care home	Service Provision	Max capacity of residents	Size of owning organisation	Owning organisation/ business type
Intervention Care Homes (IAP)	CH 1	Residential	42	Medium, national	Not for profit
	CH 2	Nursing	45	Large, National	Private
	CH 3	Residential	56	Large, National	Not for Profit
	CH 4	Residential & Nursing	40	Small, Local	Local Authority

	CH 5	Nursing	86	Large, National	Private
	CH 6	Residential	30	Medium, National	Not for Profit
	CH 7	Residential	15	Small, Local	Private
	CH 8	Nursing	30	Small, Local	Local Authority
	CH 9	Residential	58	Medium, National	Not for profit
Active Control Care Homes (Non-IAP)	CH 10	Residential	28	Large, National	Not for profit
	CH 11	Residential & Nursing	26	Large, National	Not for profit
	CH 12	Residential & Nursing	91	Large, National	Private
	CH 13	Nursing & Residential	120	Large, National	Private
	CH 14	Residential	33	Medium, National	Private
	CH 15	Nursing	40	Medium, National	Private
	CH 16	Residential	38	Medium, National	Not for profit

5.1.5 Care home activity programme

To fit the study criteria, the activity programmes must have planned to run at least one session a week for a minimum of eight weeks. The intergenerational activity programme must have brought together children between the ages of 5-18 and older adults aged 65 and over, in a care home setting. The activity programme in the non-intergenerational setting was business as usual. Intergenerational activities and non-intergenerational activity programmes were set to run regardless of this research project.

The intergenerational activity programmes referred to introduced socialisation and interaction between younger people and older adults living in residential or nursing homes. The older adults were the responsibility of the care staff within the care home and the younger people were the responsibility of the school teaching staff. One intergenerational activity programme

was led by a charity organisation, all children involved in this programme were from local secondary schools in the area and were the responsibility of the organisations representative. The non-intergenerational activity programmes were 'business as usual' in care homes that regularly delivered activity programmes. All the intergenerational activity sessions took place in the activity rooms within each of the care home facilities. The programmes organised and co-ordinated by care home staff, teachers and/or third sector, independent of the researcher's involvement.

The study aimed to evaluate the real-world practice of care homes across South Wales and focuses on the overall effectiveness of the activity programmes across different sites and settings. The type of activities did not form part of the inclusion/exclusion criteria, instead the focus was more on the relationships between different generations and the pleasure derived from carrying out a meaningful activity rather than being about the activities themselves (Santini, Tombolesi, Baschiera, & Lamura, 2018). To have controlled for each of the types of activities run in each of the settings would have required much greater resource and funding beyond the scope of this study. Dates were set for the programme to commence, and screening and baseline data collection were collected before this date. Throughout the process researchers kept in contact with the care homes to see how they were progressing with the programmes. Detailed findings relating to the types of activities run can be found in section 7.1.

5.2 Research Participants

5.2.1. Participants Sampling Strategy

Purposive sampling was also used to identify participants needed for the study. This sampling strategy was guided by the literature review and the potential impact intergenerational activity and non-intergenerational activity programmes could have on people within care homes. Having identified three target participant groups (Older adults, younger people and care staff), purposive sampling strategy was used to identify those from the target populations set out in this study. This sampling strategy required the researcher to make judgement about the sample that is going to be most helpful in contributing to the purposes of the research. In addition to care homes inclusion and exclusion there were also additional criteria related to participants.

5.2.2. Participant Inclusion Criteria

Older Adults – Any male or female age sixty-five years and over residing in selected residential and nursing care homes, able to understand verbal English, scored 10 or above on the Montreal Cognitive Assessment (MOCA) (indicating sufficient of cognitive ability) and provide informed consent. For a more detailed discussion on informed consent please section 5.9.

Care Home Staff- Any male and female care home staff in selected care homes who were regularly involved or linked to the activities run the care home, having direct contact with the activity programmes and the residents taking part in them. All care staff were required to understand verbal and written English and provide informed consent.

Younger People - Male and females, aged between five and eighteen years old involved in intergenerational activities within the selected care homes. By including those between the ages of 5-18 in this study it meant the recruitment and selection criteria was more manageable for me as the researcher as it included children who attend primary or secondary school. All were required to understand very basic verbal English, obtain parental/guardian consent and provide either informed consent (11-18-year-olds) or assent (5-10 year olds) themselves. Please see appendix 3 for all of the stakeholder consent forms.

5.2.3. Participant Exclusion Criteria

Older Adults- Any resident younger than sixty-five years of age, not residing in one of the registered residential care or nursing homes selected for the study. Older adults living in the care home but who were not involved in the intergenerational or non-intergenerational structured programme activities. Those that were willing to take part but lacked the ability to give informed consent, following an assessment and judgement of mental capacity by the researcher. Finally, older adults that did not understand verbal English or scored <10/30 on the cognition screening (MoCA).

Care Home Staff - Any care staff not working in one of the registered residential care or nursing homes selected for the study. Care staff who could not understand verbal English, or were not involved in or connected to the activity programmes or residents attending the programmes.

Younger People - Any younger persons above the age of 18 and were not taking part in intergenerational activities programmes in one of the registered residential care or nursing homes selected for the study. Younger people that do not understand verbal English or failed to provide parental consent and either written consent if age between 11-18 years old or assent if age between 5-11 years old.

5.2.4. Participant Recruitment

The participant recruitment process utilised a staged approached. For residents and care staff, prior to approaching individuals to participate in the research the researcher made sure to familiarise myself to the residents and care staff by arranging as least two visits to the care home before commencing any data collection. This enabled a more relaxed and less institutionalised 'outsider' approach, where the residents and care staff were able to feel more comfortable with my presence and less sceptical as to aims and objective of the research. In addition, posters were created and placed in communal areas of the care homes to provide information about the researcher and familiarise individuals of the research that was being undertaken. This again helped to reaffirm why the researcher was visiting the care home. The researcher was dependent on the care staff for recruitment of older adults to the study, with the care staff acting as gate keepers in all settings. Care staff helped to initially identify residents who they felt might be able and willing to be involved in the research using their pre-existing knowledge relationships with the residents in the care home.

A sample size calculation was based on residents' quality of life as measured by QUALIDEM (Ettema, Dröes, De Lange, Mellenbergh & Ribbe, 2007). Using an effect size (δ) of 0.33, a significance level α of 0.05 (two sided) and a power of 90%, 84 residents would be needed in each group. Based on previous research on drop-out rates (Verbeek, van Rossum, Zwakhalen, Ambergen, Kempen & Hamers, 2009) the research aimed to include 130 residents in each group (260 in total). Repeating the power calculation using Dementia Care Mapping as a quality-of-life indicator instead of QUALIDEM and taking drop out into consideration, also indicated that 130 residents would be required per group (Brooker, Argyle, Scally & Clancy, 2011). Although the final selected primary outcome measure used in the study was DEMQOL, the sample size calculations using two other similar quality of life measures were sufficiently robust to determine an appropriate sample size.

Older Adults - In all facilities, care home staff helped identify potential participants age 65+ and above, who routinely took part in activities and met the inclusion criteria, a recruitment process similar to other research exploring IAP in care homes (Di Bona et al., 2019). Potential participants were informed about the nature of the activities that would be happening within the home over the next two months and asked informally if they thought that these types of activities would be something they were interested in. Care staff were often present when the researcher was having such conversations with the residents and they were able to join the conversation. Following this, individuals were asked if they would like to also participate in the research study. Once potential participants had been identified, they were verbally informed about the nature of the research and asked if they had any questions in relation to the study. Once the researcher ascertained that the participants had no further questions and indicated that they felt comfortable and that they would like to participate the researcher then obtained informed consent from the participant (see section 5.9). Originally participation rates of ten to twenty older adults per care home were targeted however these were not met due to a number of factors such as resident illness and family visitors at the time the activity was running.

Care Home Staff - To determine the care staff that were most responsible for the running and planning of the activities, the researcher met with the care home manger and activities co-ordinator to identify staff that were routinely scheduled to be working on the day that the activities were delivered, and who were linked to the running of the activities. Once care staff were identified they were approached by the researcher to take part in the research and provided with information about the study both written and verbally. This approach was used both in the non-intergenerational and intergenerational care home settings.

Younger People - The point of contact for the younger people were 'gate keepers' such as teachers, group leaders who were responsible for engagement in the intergenerational activities. All children identified to participate in the intergenerational activity programmes were invited to take part in the study. Gate keepers distributed the relevant participant information forms and consent forms to the younger people and their parents or guardians. Once the younger people had been made aware that the research would be taking place and parental consent (appendix 3) was obtained the researcher invited the younger people to take part in the study providing them with the relevant and age appropriate information sheet (appendix 2) and verbally explain the information face to face. The younger people were also informed that they

were able to decline to take part regardless of the consent from parents/guardians, and without it affecting their engagement in the activities.

5.3. Data Collection

This section provides details of the standardised questionnaire measures used with each of the participant groups. It outlines when and how they were used throughout the data collection process of this research across each of the time points and in both settings. An overview of the specific measures used at each timepoint can be found in table 13. The overall data collection procedures remained the same in both the intergenerational and non-intergenerational active control settings apart from the inclusion of younger people in the intergenerational settings. Non-intergenerational settings only included older adults and care staff. Later on in this section an overview of the whole data collection procedure can be found in Figure 77.

5.3.1. Measures

The questionnaires used at T0, T1, T2 and T3 were made up of standardised and validated Likert-type scales, as well as semantic differential scales in order to capture a number of outcomes for each participant group. These standardised scales were collated to create quantifiable questionnaires for each participant group.

Table 13

Summary of phases and associated measures, participant, and time point

Time point	Methods	Measures	Stakeholder group	Timing
Time point (T0)	Screening Questionnaire	MOCA; ADL	OA	Two weeks prior to start of intervention
Time point 1 (T 1)	Pre-intervention questionnaires (Baseline)	DEMQOL; EMAS; GDS; SAHS; De Jong Gierveld	OA	One week prior to start of intervention
		CATE	YP (IG only)	
		MJS; ADS; SDCS; CWEQ-II	CS	
Intervention	Intervention	Facilitators Field Note Handbook	CS	Intervention lasting a minimum of one hour weekly session

				for at least eight weeks
Time point 2 (T2)	Post-intervention questionnaires	DEMQOL, EMAS, GDS, SAHS, De Jong Gierveld	OA	Eight weeks after phase 2
		CATE	YP (IG only)	
		MJS, ADS, SDCS, CWEQ-II	CS	
	Qualitative Interviews	Semi Structured in Depth Interviews	OA, YP, CS	Eight weeks after phase 2
Time point 3 (T3)	Follow up questionnaires	DEMQOL, EMAS, GDS, SAHS, De Jong Gierveld	OA	Twelve weeks after baseline
		CATE	YP (IG only)	
		MJS, ADS, SDCS, CWEQ-II	CS	

5.3.1.1.Older Adult Outcomes Measures

Montreal Cognitive Assessment (MoCA English- version 7.1) - The Montreal Cognitive Assessment is a brief and simple screening tool to determine the older adult's level of cognitive functioning and subsequently their eligibility to take part in this research. MoCA is rated on a 30 point scale and assesses a number of different cognitive components: visuospatial/executive (5 points); naming (3 points); memory (5 points for delayed recall); attention (6 points); language (3 points); abstraction (2 points); and orientation (6 points). Scores are summed and a point is added if the participant has ≤12 years in education. The optimal cut off point for a diagnosis of cognitive impairment diagnosis is ≤ 25, with 18-25 presenting mild impairment, 10-17 moderate impairment and less than 10 indicating severe cognitive impairment. MoCA is sensitive to subtle cognitive deficit (Nasreddine et al., 2005). MoCA demonstrates good internal consistency, yielding a Cronbach alpha score of 0.83 (Nasreddine et al., 2005), and in this study the alpha co efficient was .75. It has good test-retest reliability and convergent validity in patients with Parkinson's disease and stroke populations (Gill, Freshman, Blender, & Ravina, 2008; Godefroy, Fickl, Roussel, Auribault, Bugnicourt, Lamy, Canaple & Petitnicolas, 2011). However, MoCA scores were not included in covariate analyses.

Activities of Daily Living - Functional status of the older adults was obtained using the modified Barthel Activities of Daily Living Collin, Wade, Davies, and Horne (1988). This is a10 item ordinal scale that measures the self-reported functional independence with a completion time of 2-5 minutes. It has two overarching domains of personal care and mobility, which include questions relating to bowel and bladder use, grooming, toilet use, feeding, transfer ability, mobility, dressing, stairs and bathing. Scores for each item are based on a three-point scoring system with a total score range from 0 to 20. Functional categories are scored from 0 to 1, 0 to 2, or 0 to 3, depending on the function (Collin et al, 1988), cut off values of 0-11 for high dependency, 12-17 for mild dependency and 18-20 for low dependency (Lam, Lee, & Yu, 2014) were used. The BI was found to be reliable when administered by face-to-face interview and by telephone (0.89) and on testing by different observers (ICC 0.95–0.97) As with the MoCA, Individuals from non-intergenerational settings and intergenerational settings were matched with participants who scored similarly in these activities of daily living by using these cut off scores.

Dementia Quality of Life (DEMQOL Version 4) - DemQoL was used to assess the quality of life of residents living in care settings. The scale comprises 28 items with responses reported on a four-point Likert scale (1.A lot, 2. Quite a bit, 3. A little, 4. Not at all). DEMQOL measures QOL across four domains; these include 1.Daily activities, 2. Memory, 3. Positive emotion and 4. Negative emotion. A number of questions required reverse scoring, in order that a high total sum score was representative of a better health related quality of life. Psychometric evaluation in mild and moderate dementia patients revealed evidence of high reliability with a Cronbach's alpha co-efficient of 0.94 (S. C. Smith et al., 2005), in this studies sample the alpha co efficient was .74.

Engagement in Meaningful Activities Survey - The 12 item adapted EMAS test (Eakman, 2010) was used to capture the extent to which older adults believed the activities to be meaningful. The EMAS has been used with college students, veterans and older adults, and requires participants to provide responses to statements about activities they normally engage in on a 4 point scale (1=Rarely, 2=Sometimes, 3=Usually and 4=Always). Scores are obtained by summing scores from each of the 12 questions, resulting in a possible range of 12-48. Subsequently, scores can be interpreted as being either low meaningfulness (EMAS < 29), moderate meaningfulness (EMAS 29 – 41) or high meaningfulness (EMAS > 41) (Eakman et al, 2010). Regression analyses (Eakman, 2010) demonstrated that purpose and meaning in life consistently predicted the EMAS and its components, and whilst the scale has moderate test-

retest ability at .56, the Cronbach Alpha demonstrates good internal consistency at .89 and in this studies sample the alpha co efficient was .81. Overall, evidence supports EMAS as a valid measures of meaningful activity in older adults and has demonstrated a high correlation with the purpose in life test (r = .57, p < .01) (Eakman, 2010). This scale has been successfully used in long term care settings (Mansbach, Mace, Clark, & Firth, 2017).

Geriatric Depression Scale Short Form- The Geriatric Depression Scale (GDS-15) This is a 15 item format self-report measure (Sheikh & Yesavage, 1986) for brief assessment of depressive symptoms amongst older adults with and without cognitive impairment (Conradsson et al., 2013; Mitchell, Bird, Rizzo, & Meader, 2010) and has been used in previous studies evaluating the impact of intergenerational activity programmes (Skropeta et al., 2014). Derived from the GDS 30 item original version by Yesavage et al. (1982), the GDS-15 has fifteen questions with a simple yes/no response format in order to make it as easy as possible for older adults with cognitive impairment to understand (Conradsson et al., 2013). Questions are asked in relation to how the participant has felt over the last week. Higher scores are indicative of increased depressive symptoms, with scores between 5 and 11 indicating the presence of mild to moderate depression and between 12-15 demonstrating increased likelihood of more severe depression (Greenberg, 2012). Despite its brief nature, the GDS 15 still demonstrates a high correlation with the original GDS30 (r = 0.84) (Sheikh & Yesavage, 1986). A large scale review by Wancata, Alexandrowicz, Marquart, Weiss, and Friedrich (2006), identified sensitivity and specificity of the GDS 15 at 80.5% and 75.0% respectively. This measure has been used with a diverse older adult care home population (Conradsson et al., 2013; Marc, Raue, & Bruce, 2008).

Self-Assessed Health - This study used a standard self-assessed health status (SAHS) question (Crossley & Kennedy, 2002), '*In general, would you say that your health is…*' A 5-point response Likert-type scale was used to score responses as followed: 1-Excellent, 2-Very good, 3-Good, 4-Fair and 5-Poor) with higher scores representative of poorer self-perceived health.

De Jong Gierveld Loneliness scale - Designed specifically for use with older people (Gierveld & Tilburg, 2006), this 6 item loneliness scale was used to capture both the social and emotional components of loneliness felt by the older adults (Weiss, 1973). A paper titled 'Lonely but not alone', Van Baarsen, Snijders, Smit, and Van Duijn (2001) suggests that emotional loneliness is linked to the 'Absence of a specific attachment figure', with social loneliness relating more

to the ‘lack of social integration and meaningful relationships’ (Van Baarsen et al., 2001, p. 132). This De Jong Gierveld Loneliness scale has been used in care homes internationally with large sample sizes (Jongenelis et al., 2004; Prieto-Flores, Fernandez-Mayoralas, Forjaz, Rojo-Perez, & Martinez-Martin, 2011). It is comprised of 3 negatively worded statements (1-3) (‘‘*I experience a general sense of emptiness’’, ‘‘I miss having people around’’* and *‘‘Often, I feel rejected’’*) and 3 positively worded statements (‘‘There are plenty of people that I can lean on in case of trouble’’, ‘‘*There are many people that I can count on completely*’’ and ‘‘*There are enough people that I feel close to*’’) (4-6), with response options of ‘*Yes’, ‘More or Less’* and ‘*No*’. Scores range from 1 to 6, with the neutral and positive answers on negatively worded statements scored as ‘1’ and negative answers as ‘0’. Neutral and negative answers on positively worded items are scored as ‘1’ and positive answers as ‘0’. A total score between 0-6 is summed, with lower scores indicate less feelings of loneliness.

Gierveld and Van Tilburg, ensured none of the items referred to loneliness directly with the word loneliness not used at all. The scale has proven reliable (0.81 and .85 respectively) in numerous countries (Gierveld & Van Tilburg, 2010) and in this studies sample the alpha co efficient was .62. It has been validated for assessment of loneliness in older people in long term care settings (De Jong Gierveld & van Tilburg, 2006; Penning, Liu & Chou, 2014).

5.3.1.2. Care Staff Outcome Measures

Job Satisfaction - A 22 item measure of job satisfaction (MJS) questionnaire was developed for use with community nurses (Traynor & Wade, 1993). The MJS has since been examined and validated as a reliable and valid instrument for assessing staff satisfaction in residential aged care settings (Chou, Boldy, & Lee, 2002) without being too burdensome for the staff. Questions cover personal satisfaction, workload, team spirit and training. The response scale used is a five point satisfaction scale, with 1 representing “Very Dissatisfied’ and 5 representing ‘Very Satisfied’. A greater total sum score indicates greater satisfaction. The Cronbach's alpha reliability levels range from 0.86 to 0.95, with convergent and discriminant validity also satisfactory (Chou et al 2002).

Attitudes towards dementia - The approaches towards dementia questionnaire (ADQ) (Lintern & Woods, 1996) comprises 19 questions relating to two subscales: hope (8 items) (e.g. “There is no hope for people with dementia”) and recognition of personhood (11 items) (e.g. “People with dementia need to feel respected, just like anybody else”). The sub-scale, ‘hope’, predicts

staff behaviour in terms of social interaction with people with dementia, involvement in activities and stimulation and the quality of care interactions (Lintern and Woods (1996). Participants score each item on a five point agreement scale with 1 representing 'Strongly Agree' and 5 representing 'Strongly Disagree' 5. A higher total sum score is representative of a more positive approach towards individuals with dementia. The scale has been shown to have good internal reliability (Cronbach's Alpha 0.83) and good test-retest reliability (0.76) (Lintern & Woods, 1996) and in this studies sample the alpha co efficient was .78. In addition to this the ADQ scores have been shown to converge with scores derived from responses to video vignettes, the dementia styles questionnaire, and staff behaviour observations indicating its validity (Lintern, 2001).

Work Empowerment - Care staff feelings of empowerment were measured using the conditions for work effectiveness questionnaire two (CWEQ-II) (Laschinger, Finegan, Shamian, & Wilk, 2001); a shorter version of the Conditions for Work Effectiveness Questionnaire (CWEQ) (Chandler 1986). This questionnaire is designed to measure the four different dimensions of empowerment each used as a subscale, relating to care staff's perceptions of 1. The access of opportunity, 2. The access to Information, 3. The access to support, and 4. The perceived access to resources. Each subscale contains three items, and a response scale of 1 to 5, with 1 representing 'None' and 5 representing 'A lot'. A subscale mean score is obtained by summing and averaging the items. An overall empowerment score was calculated by summing the four subscales. Higher scores indicate feelings of greater work empowerment in their current work environment. Scores can range from 4 to 20. Total scores falling between 4 and 9 described a low level empowerment, 10 to 14 as moderate and 16 to 20 representing high levels of empowerment (Laschinger et al., 2001). Construct validity of has been confirmed, with cronbach alphas ranging from = 0.74 to a = 0.89 and item-total correlations ranging from 0.44 to 0.85 across subscales (Laschinger et al. 2001).

Strain in Dementia Care Scale (SDCS): This scale developed by Edberg, Anderson, Wallin & Bird (2015) is made up of two sub scales. Section one comprising of 27 items looking at the situations, thoughts and feelings experienced by dementia care staff. It assesses five components in particular: 1). Frustrated empathy, 2). Difficulties understanding and interpreting, 3). Balancing competing needs 4). Balancing emotional involvement and 5). Lack of recognition. Participants were asked to provide responses to statements on two, four point responses scales or each of the 27 items; First in relation to how often the situation occurs

(1=Never to 4=Very often) and subsequently the amount of stress it might cause when such situations occur (1=No stress to 4=High Stress). Frequency scores are multiplied by stress scores (range 1–16) and then divided by the number of items (27) in order to attain a sum total factor score. Higher scores indicate poorer working conditions and greater job strain. To date there are no suggested cut off scores, however one study reported mean values between 2.7 and 3.7 (Wallin, Edberg, Beck, & Jakobsson, 2013).

Section two is concerned with the daily emotions experienced by staff. Participants were asked "During a day of work how often do you experience the following emotions?"; Powerlessness, Satisfaction, Sadness, Frustration, Fear and Joy/Happiness. Participants were asked to provide the response on a six point scale (1=Never to 6=All the time). The scale has the potential to demonstrate improved wellbeing for the staff, however, currently there are no recommended cut-off scores for describing various job strain levels. Edberg, Anderson, Wallin, & Bird (2015) found intra-scale correlations between factors and the total score to be between 0.75 to 0.86, α-values ranging from 0.75 to 0.89 and a strong internal consistency score of r =0.94 for the total score.

5.3.1.3. Younger Person Outcome Measures

Children's attitudes towards older adults– Younger persons attitudes towards older adults was measured using the Children's Attitudes Towards the Elderly (CATE) (Seefeldt, Jantz, Serock, & Galper, 1977). This questionnaire was developed for use with children age 3-11 years old which was one of the key reasons for its use in this study. With a testing time of around 15 minutes, it has been widely used with both pre-school and school aged children in intergenerational studies (Belgrave, 2011; S. M. Cummings, Williams, & Ellis, 2003; White, 2001; Winters, 1994) and with children from different ethnic and cultural back grounds (Slaughter-Defoe, Kuehne, & Straker, 1992). The CATE covers Cognitive, affective and behavioural elements of younger persons attitudes towards older adults, both explicitly and implicitly (Mendonça, Marques, & Abrams, 2018; Wishard, 2003), via the administration of four subtests: 1) The Word Association; 2) The Picture Series; Semantic; 3) The Differential Scale and 4) The Concept of Age (Seefeldt et al., 1977). In a similar vein to Winters (1994), three of the four subsets were used: the open ended word association, the picture series and the

semantic differential scale. Each of these will now be discussed in greater detail. In this study's sample the alpha co efficient was .73.

The Word Association Sub-Scale: This subscale relates to affective, behavioural and knowledge aspects of younger people's attitudes towards older adults (Mendonça et al., 2018; Seefeldt et al., 1977). Questions relating to affective elements (e.g. "*How do you feel about getting old?*") were scored by each subject given coded score for either a positive negative or neutral response (See Table 14). If the participant provided two responses, 1 negative and 1 positive the score would be neutral and would cancel each other out.

Behavioural elements were captured by asking *"what old people do you know" and "What do you do with that person?"*. The first behavioural question was scored as belonging to either knowledge of older adult within family or other non-familial structure, with a coded score provided for a response to either of these. The second behavioural question required the younger person to respond either 'yes' or 'no' to doing either active things with older adult, passive things, or things for the older adult. One point was scored for a response of 'yes' to any of these activities. Lastly the knowledge component of younger people attitudes towards older people and the ageing process were captured by asking younger people *"What can you tell me about older people?"* and *"Can you give me another name for older people?"*, responses to these questions were scored as either being affective, physical or behavioural (See Table 14). Once responses were allocated to either of these three categories, they are scored according to the frequency of responses in each category and whether it is a positive or negative response. For example, a younger person might give 3 responses, 2 positive affective and 1 negative physical. A score for each subject in this question is determined by subtracting the number of negative responses from the positive ones. However if a child gave two responses, i.e one positive and one negative their score was coded as neutral.

The Picture Series Sub Scale: This subscale enabled measurement of younger people's attitudes towards visual representations of older adults. Participants were presented with four black and white drawings of Caucasian men at four stages of their life (approximately age 20, 40, 60 and 80) (See appendix 4). The original authors Seefeldt et al. (1977) ensured the facial expressions, ethnicity, dress code and gender remained the same for each men, leaving age as the only variable between the four images. Pictures are coded from one to four, one being the youngest and four being the oldest. These same images have been used in past intergenerational literature

research (Fernandes, 1981; Seefeldt et al., 1977; Winters, 1994). Upon presentation of the pictures, the participants were informed by the researcher that they were about to be shown four images; '*Now I am going to show you some pictures'*. Each of the laminated A4 photographs were shuffled and presented to the participant in a random order on the testing table. Participants were then asked questions in order to elicit different cognitive, behavioural and affective responses.

Younger peoples cognitive responses to the pictures were captured by the following questions: '*Which person do you think is the oldest?*' scored on their ability to recognise the oldest man (Yes/No), a follow up question of *'Why?'* scored on the basis of age recognition (No response, Physically descriptive, or Evaluative), and '*How do you think you will feel when you are that old?'* with responses scored as either (1= No response, 2 =Negative, 3= Neutral and 4=Positive). The next set of questions aimed to capture younger people's behavioural and affective attitudes towards older adults. If not identified correctly in the first question the researcher points to the image of the oldest man and asks; *'What things would you help this person do?'* (Don't know/No response, Behavioural stereotype, behavioural unique or affective), and *'What things could he help you do?'.* Responses are noted as either 0=Don't know/No response, 2=Behavioural Stereotype, or 3=Affective (Table 14).

The next question focused on the participants ability to order pictures from youngest to oldest with the researcher giving a score of either 1= Unable to order pictures correctly or 2=Able to order pictures correctly. Following this participants were ask to estimate age of men in pictures (0-99), their associational preference (1=Youngest, 2= Next youngest, 3= Next oldest, 4=Oldest) and reasoning for response (1=No response, 2=Age related, 3=Evaluative, 4= Altruistic). Examples of how such questions were worded is as followed; "Can you put these pictures in order from the youngest to the oldest?" "Which one of these people would you prefer to spend time with?"), with higher scores indicating more positive attitudes towards older adults and no response.

Table 14

Pictures series responses and examples

Type of response	Examples of potential responses
No response	Physical shaking of head or shrugging of shoulders; Silence; '*I don't know*'
Physically descriptive	*'He has wrinkles'*, '*He doesn't have as much hair'*
Negative	*'He's mean', 'Sad, 'Bad'*
Neutral	*'He's okay'*
Positive	*'He's nice' 'He looks friendly'*
Behavioural stereotype	*'Help him walk' 'Help him with his shopping'*
Behavioural Unique	*'He is really good at sports'*
Affective	*'Love me'*
Age Related	Any response that referred specifically to age *"he's younger" or "he's older"*
Altruistic	A response that was unselfish and had the older person's best interest in mind *"I want to take care of him*"
Evaluative	A response that was an opinion or judgment of the subject *"I chose him because he's nice"*
With Active	*Responses that indicated movement between the subject and the elderly person*
With Passive	*Responses that indicated doing a quiet activity between the subject and the elderly person*
For	*Responses that indicated either the participant or the older adult did something for the other person*

Note. This is adapted from (Winters, 1994)

The Semantic Differential Sub Scale: This subtest was used to capture younger people's evaluative dimension of their attitudes. It is comprised of two semantic differential subscales, both had the same 10 items (Good/ bad, Sad/Happy, Right/Wrong, Terrible/Wonderful, Pretty/Ugly, Unfriendly/Friendly, Clean/Dirty, Poor/Rich, Healthy/Sick, Harmful/Helpful) and a 5 point bi-polar scale. These semantic scales differed in relation to who the scales were being asked about; either younger people or older adults and the order and polarity of the items

presented in an effort to reduce response bias. The order of items listed above was the order and polarity used for the younger persons scale with the opposite order of items and opposite positioning of the polarity i.e (Good/bad into Bad/Good). When the younger participant responded to either of the polarities, the intensity of their response was investigated further by the researcher. For example, if the participant choose 'Good' over 'Bad', the researcher asked whether they would choose 'Very good, good, or a little good', enabling the researcher to mark the corresponding response on the 5 point scale. This process was repeated for each of the ten items, on each of the 'Younger people' and 'Oder people' semantic differential scales. All items were coded so that a higher score corresponded with the more positive adjective (eg Very Bad = 1 and Very Good =5). After items were coded accordingly, a score for the each of semantic differentials (Younger people and older people) was calculated by summing each of the responses to both the semantic differential scales. Sum scores for each scale ranged from 10-50 (Winters, 1994). Research has demonstrated a reliability co-efficient of α =.81 for this subtest (Cummings, Williams and Ellis, 2002).

An overall total CATE attitudinal score was calculated by summing the scores from the word association, the Picture Series and Semantic differential sub scales. Higher scores representing a more positive attitude towards older adults (Seefeldt et al., 1977).

5.3.1.4. Other participant measures

All participants were asked basic demographic questions. For younger people these included, questions relating to the gender (1. Male, 2.Female, 3. Non-Binary, 4. Prefer not to say), age (Years). For older adults and care staff these included information about age (in years), gender (1. male, 2. Female, 3.non-binary, 4. prefer not to say), marital status (1. single, 2. co-habiting, 3. married, 4. widowed, 5. divorced, 6. civil partnership), education attainment (1.degree or equivalent, 2. higher education, 3. A Level or equivalent, 4. GCSEs grades A*-C or equivalent, 5. other qualifications, 6. no qualification), and ethnicity (1. white British, 2. mixed/multiple ethnic groups, 3. Asian/Asian 4.British, Black/ African/ Caribbean British, 5.Chinese, 6. Arab, 7. Other).

In addition to the generic social demographic questions outlined previously additional single items questions specific to each of the participants groups were also asked. These were as follows; Older adult participants were asked how long they had been living in the care home (Years and Months). Younger people were asked who lived at home with them (Open ended),

how often do they interact with older adults (Daily, Monthly, weekly), and if they have ever visited a care home before (Yes/No). Care staff were asked about their contracted working hours (Full Time, Part Time, Student, Other), job title (Care Home Manager, Nurse/Senior Carer, Care Assistant, Activity Co-ordinator, Other), and how long participant has worked in the care home (Months/years).

5.3.2. Data collection procedures

Time point 0: Screening (T0)

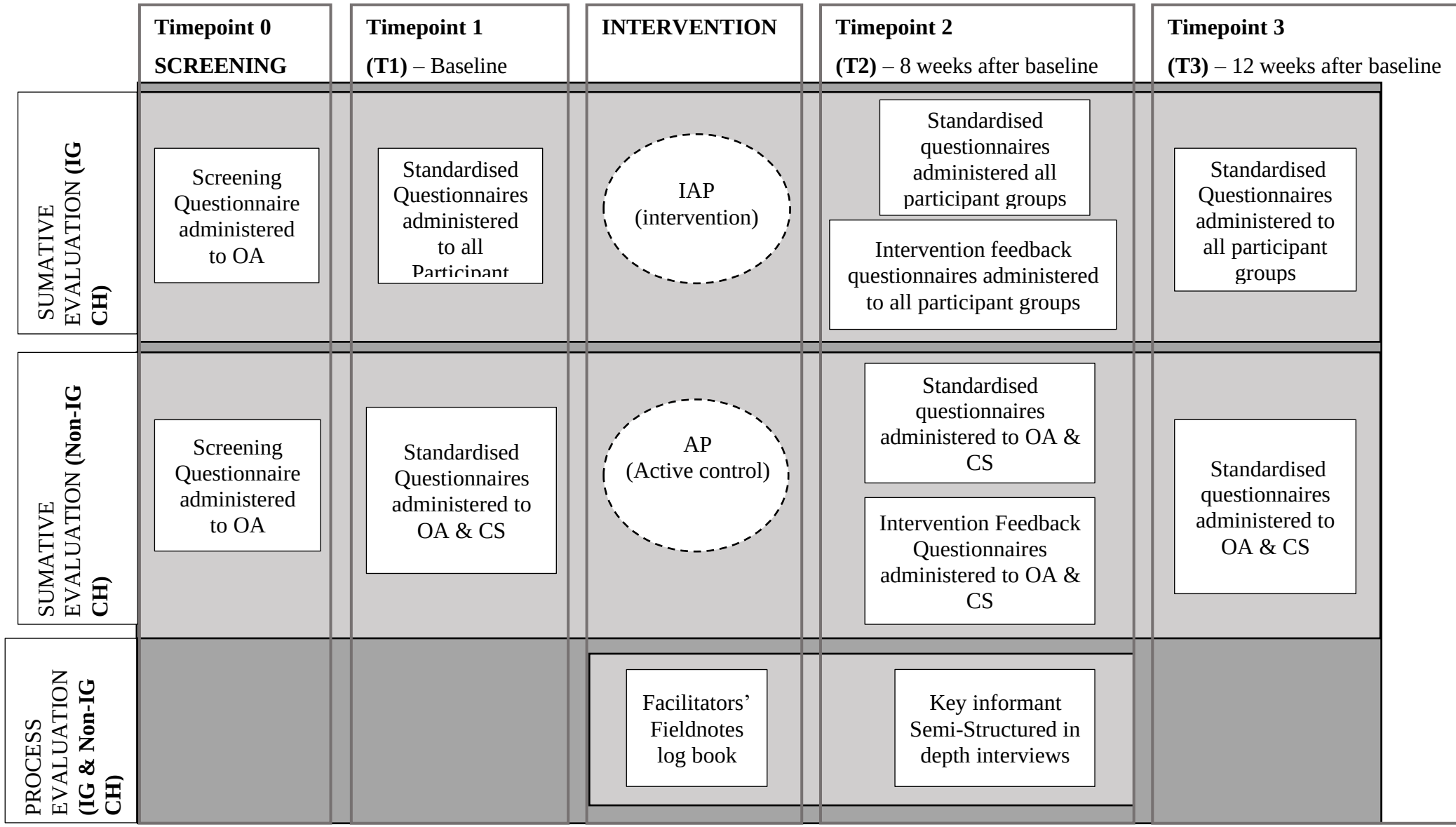
Screening was carried out at T0 with the older adult residents in both setting approximately one week prior to baseline measurement. The total scores from each screening measure were assigned labels of low, mild, and high dependency, and either severe, moderate, mild or no cognitive impairment across both intergenerational and non-intergenerational groups. This was the first phase of the study and scores from the cognitive assessment measure (A score of 10 or more) helped the researcher identify if the older adult was eligible to take part in the study. Scores from both the cognitive assessment and assessment of activity daily living questionnaires were then used to match older participants across the intervention and control settings. More detail about these measures can be found in section 5.

Time point 1: Baseline (T1)

Having formally identified older adults that were eligible to take part in the research through screening and matched them across setting, further eligibility assessments (see inclusion and exclusion criteria in section 5.4.1. and 5.4.2) were conducted with care staff and in the intergenerational setting, younger people. Three separate questionnaires were used, one for each participant group: older adults, younger people and care home staff. For the younger people and older adults, the outcome measure questionnaires were administered face to face by the researcher. Questionnaires conducted within the care home and school settings, were done so in a quiet space where people were not able to hear the interview. For one of the care homes, younger people were involved via a mental health charity intergenerational programme. In this instance the interviews were conducted in the charities offices. The researcher projected

Figure 7

Methodological framework for research design



her voice and spoke as clearly as possible in order to ensure that those with hearing or cognitive impairment, understood fully what was being asked. The questions were repeated if necessary. The researcher regularly checked whether the participant was comfortable in order to counteract any nervousness or shyness and to elicit credible responses and to check whether they needed a break, and if they were happy to continue or wanted to withdraw.

For care staff questionnaires were to be self-completed. When the researcher was conducting interviews with the older adults in the relevant care home, eligible care staff were provided with the self-complete questionnaires. Eligible care staff received a pack which included, the participant information sheet, a copy of the consent form, the self-complete questionnaire (T1), and a free post envelope in the week prior to the activity programme starting. The free post enabled the care staff to either complete the questionnaire of the day of the researcher visit or in their own time. This was the same process used at T2 and T3. With all the questionnaires it was vital to ensure questionnaires were succinct and unambiguous, yet still maintained their ability to capture necessary outcomes (Burns, 2000).

Intervention

The researcher was not present at the time the activity programmes were being delivered. This was not feasible due to the number of care homes included in the study and limited time and resource of the researcher. In order to capture the processes used to deliver and implement the interventions (for the process evaluation) facilitators were provided with booklets (Appendix 10) to capture the context, the number of sessions run, the number of sessions attended by participants, and fidelity of each of the sessions each week (Oakley, Strange, Bonell, Allen, & Stephenson, 2006). The booklet also had space for the facilitator to provide a summary of the sessions, prompt questions were used to guide responses such as *What happened? Was the content of the sessions delivered as planned? Were there any reasons individuals could not attend?*. The booklets were kept simple in order to encourage and not deter care staff from completing it after every session, if too much information was required, the facilitator may have been less likely to fill out the booklet every week.

Time point 2: Eight Weeks after baseline (T2)

The researcher returned to relevant organisations (school or care home) and administered the questionnaires used at baseline with each of the three stakeholder groups. At T2, an

intervention feedback questionnaire was also used which comprised open-ended and closed questions. The feedback questionnaires aimed to capture individual experiences of and underlying process of the activity programmes, eliciting feedback about challenges, opportunities, and experiences of the activities at T2. For the younger people and older adults, the intervention feedback questionnaires were administered face to face by the researcher, directly after the standardised questionnaires. For care staff the intervention feedback questionnaires were added onto the standardised questionnaire to be self-completed and the same process outlined at T1 was repeated. Semi-structured interviews were also conducted with select participants, more information on these can be found in chapter 5, section 5.4.2. For descriptive statistics on all data collection methods see chapter 6, section 6.1.

Time point 3: Twelve weeks after baseline (T3)

The three month follow up used the same process described in T2. Finally, participants were thanked for their time and asked if they were interested in hearing about the findings from the study, if so, an email address was taken to be stored for findings to be disseminated. Email addresses were held for 6 months after the completion of the thesis in accordance GDPR regulations.

5.3.3. Semi Structured Interviews

Qualitative elements of data were collected at T2 (see above) (Figure 7). To elicit feedback and gain greater insight into the participants experiences at T2, face to face semi structured interviews were conducted with a small sub sample of older adults and care staff, in both intergenerational and non-intergenerational settings. Younger people were not included in the semi-structured in-depth interviews and were only asked about their experiences, thoughts and feelings about their involvement in the activity programmes via more informal open-ended feedback questionnaires discussed previously.

Older adults - Out of the residents who the researcher had already conducted a questionnaire with at T1 and T2, the care staff helped the researcher identify residents who had routinely engaged in the activities and would be most beneficial to speak to in eliciting their views about the activities via the semi structured interviews. Following completion of the questionnaire at T2 these participants were asked whether they would be willing to take part in an additional one to one in-depth interview about the activities.

Care staff - Throughout the data collection phases the researcher identified the staff most involved in the running and delivery of the activity programmes and who had completed questionnaires at T1 and T2. These staff members were approached by the researcher and asked whether they would be willing to take part in an additional one to one in-depth interview about the activities. The researcher organised a time and date that was convenient.

The semi structured interviews were conducted between February 2019 to December 2019. All in depth interviews were recorded using an Olympus WS-812 Stereo recorder. The decision was made to record the interviews and transcribe at a later point, this meant the researcher was able to dedicate full attention to the interview content and suitable prompts, avoiding the distraction of having to make in interview notes (Jamshed, 2014).

The target sample size for the semi structured interviews was 20. Including, 5 older adults and 5 care staff from intergenerational settings and 5 older adults and 5 care staff from non-intergenerational settings. A total of 33 people from all stakeholder groups were approached to take part in semi structured interviews; 20 people from the intergenerational settings and 13 were from the non-intergenerational settings. The research conducted more interviews than originally intended, the researcher also found value in speaking with two facilitators who were linked to the school. Although these were not technically care staff and had not completed care staff questionnaires they were heavily involved with the IAP and provided insight into the processes of delivery. The interviews varied in terms of length ranging from 15-45 minutes. Of those that were approached to take part in the interviews, four individuals from the older adults stakeholder group declined to take part. **Table 15** outlines how many interviews were conducted in with each stakeholder group across the two settings. Out of this sample, all bar three were female. All interviews were conducted on a one to one basis within the care home setting. Anonymisation protocols were followed by not using the participants name throughout the duration of the interview and when audio files were uploaded to the USB device, all files were assigned a unique participant ID.

Table 15

Number of semi-structured interviews conducted with older adults and care staff across both settings

	Setting		Total per stakeholder group
	IG	Non-IG	
Older adults	8	6	14
Care Staff	12	7	19
Total per setting	20	13	

Interview guides (appendix 5) were prompted by themes extrapolated from the literature review and concurrent with the overall research questions and aims. Overall the questions invited the participant to tell their story and aimed to share their experiences, feelings and attitudes towards the activities they engaged in over the 8 week period. Questions for each of the participant groups covered various themes such as; reflection on the activity programme, communication, relationships, significance of activities, beliefs, issues or concerns. Questions relating to additional themes such as 'work satisfaction' were incorporated in the interview guide for care staff. Questions were open ended starting with adverbs such as what, how and why. Initial questions such as 'What is it like living here' and 'What are your favourite hobbies' were posed to the older adults to make the participant feel at ease, questions got progressively more specific as the interview went on in order to elicit more in depth accounts of the topic of interest. Interview prompts such as '*What do you/ did you think/feel about this?', Can you give me an example?,* and '*Uh-huh, please continue'* were used in conjunction with the interview guide in order to prompt/encourage further responses.

The interviews were conducted in a similar vein in both intervention and active control groups, with the same question topic guides used in both settings but the open-ended questions were worded slightly differently. When the researcher was asking questions to the participant who had been involved in the intergenerational activity programmes they reiterated the point that the mention of activities were relating specifically to the intergenerational activities they have been involved with the children (and not other organized activities that they may have been engaged in). The following is an example of how the questions differed slightly between

settings; *'Did you have any concerns before the start of the intergenerational activities programme?', 'Did you have any concerns before the start of the activities programme?'* .

Research field notes captured characteristics, and time and date of the interview and reflexive thoughts about the interview itself, which were also used to supplement the qualitative data. The researcher made sure to keep interruptions to a minimum in order to reduce any bias, and allow the participant to discuss experiences that they found important and noteworthy.

5.4. Analytical procedures

The mixed method approach adopted by this research resulted in both quantitative and qualitative data analysis methods, whereby quantitative data provided a summative account of specific outcomes across the different data collection timepoints, and qualitative data formed the majority of the process evaluation; both were analysed separately.

5.4.1. Summative (Quantitative) data analysis

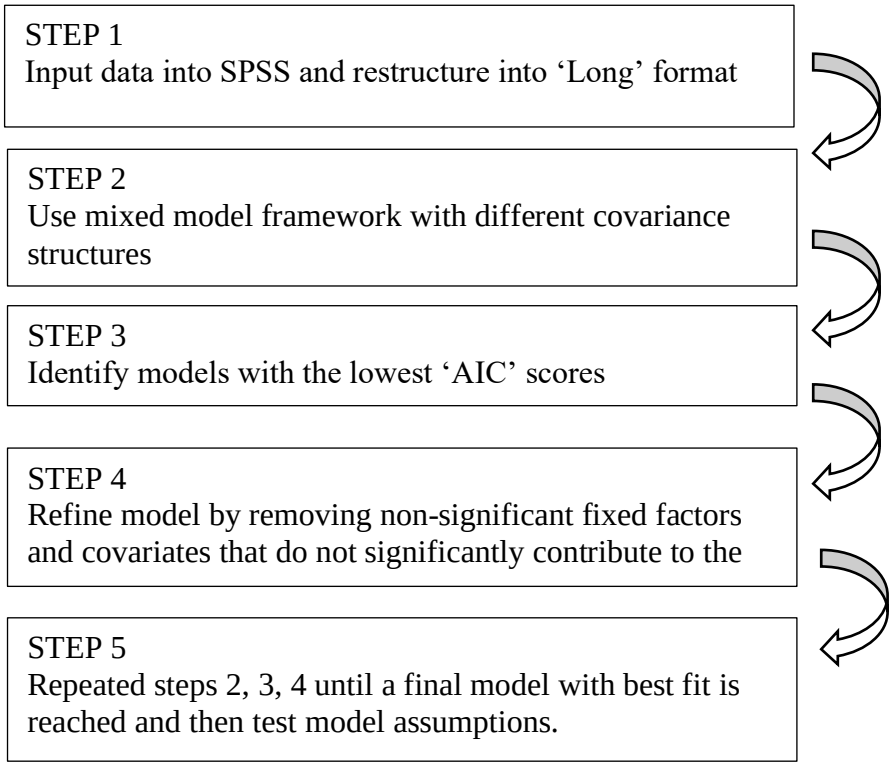
Outcomes for residents and care staff were analysed using a linear mixed model. This type of model takes account of the two levels of clustering of the data: outcome measures on the same individuals on repeated occasions (e.g. 0 weeks, 6 week and 3 months following treatment), and clustering of individuals within particular care homes. The outcomes were used as dependent variables. Fixed effects (independent variables) were time, setting, and the interaction between the time and setting. Baseline comparisons between demographic and screening variables for OA and CS in intergenerational and non-intergenerational participant groups were examined using ANOVA for continuous variables, Pearson's chi-squared tests for categorical variables and Mann Whitney-U for ordinal variables. Repeated measures ANOVA were used to test the hypothesis that the young people's attitude towards older people significantly improved over the course of the intervention. Alpha for significance was set at 0.05 for all analyses. Statistical analyses were conducted using IBM SPSS 22.

Figure 8 highlights the steps taken to identify the type of covariance structure and identify the best fitting model through Akaike Information Criterion (AIC). AIC estimate the quality of statistical models for each set of data relative to other models with lower scores indicated better fit. In the preliminary analysis, three different models for each of the outcome measures were run using the following covariance structures; compound symmetry; all the variances are equal

and all the covariances are equal, unstructured variance; variance and co variance are not equally correlated, and first order variance. The model with the lowest AIC determined what type of covariance structure was used for the models in the thesis. Subsequently, unstructured variance was used for all models.

Figure 8

Five step approach to analysing longitudinal data sets with missing data



Mixed liner models allowed for the clustering of repeated measures within individuals, accommodated datasets collected at unequally spaced time intervals as in this study (e.g. 0 weeks, 6 week and 3 months following treatment), as well as handling missing data, enabling flexibility when '*specifying the variance-covariance structure of longitudinal data'* (Kwok et al., 2008, p. 5). Alpha for significance was set at 0.05 for all analyses.

5.4.2. Process (Qualitative) Data Analysis

Frequencies and cross tabs were used to describe responses to closed question items on the intervention feedback questionnaires from all participant groups. As this research set out to look at a range of different intergenerational programmes across south Wales, analysis of

interview transcripts and responses to open-ended questions was conducted using thematic analysis outlined in table 16, to pull out themes from the qualitative data. All qualitative data on facilitators fieldnotes, transcriptions and intervention feedback questionnaires were entered into nViVO qualitative analysis software version 10. The researcher read the qualitative transcripts and identified and extracted key quotes that encapsulated the different codes to which they were assigned in order to enhance the credibility of findings. Once the transcripts had codes assigned to noteworthy sections of the texts, these were then categorised into groups of similar meanings and the researcher compiled a table of the key themes and sub themes that emerged from a consolidation of the different process evaluation data sources.

Table 16

Severn step process of thematic data analysis

Step	Process
Step 1	Identifying initial ideas, elements and codes during data collection
Step 2	Become familiar with the data
Step 3	Generate initial codes
Step 4	Search for themes
Step 5	Review themes
Step 6	Define themes
Step 7	Write-up

Adapted from Braun & Clarke (2006)

In line with the MCR guidelines for complex intervention guidelines, qualitative process data was collected and analysed iteratively so that themes that emerge in early interviews can be explored in later ones. Symbolic interactionism was an emerging theory from the data. It was clear from an early point in the collection of the qualitative data that these themes seemed to align with concepts from symbolic interactionism and the importance of relationships and associated meaning attached to them by the participants. As well as how these started to change throughout the course of the study. As a result this theoretical framework was drawn upon to help understand why there intergenerational activities might be more beneficial to participants than normal activity programmes within care homes. The researcher upheld the ideas of symbolic interactionism throughout the interpretation and analysis of the qualitative process

evaluation. As a result the researcher began to pick up and draw upon elements that reflected a symbolic nature.

Findings were triangulated with the quantitative summative evaluation data in order to enhance the rigor of the evaluation; increasing the internal validity and reliability of the findings (Anfara, Brown, & Mangione, 2002). Although Moore and colleagues suggested by a more detailed modelling of variations between participants and sites in terms of factors such as fidelity or reach, this was beyond the scope of the study which already set ambitious research questions and aims, given the time and resource of the researcher. The qualitative findings are presented in chapter Severn using verbatim, direct quotations from the texts, interposed with interpretations from the researcher.

5.5. Ethical Considerations and Procedures

Ethical values are fundamental to social care and research. There are a number of widely held principles that guide and enable a conscientious social researcher. The Social Research Association guidelines recognises that ethical considerations at both individual and broader societal levels must be addressed, these include obligations to society, funders, colleagues and the subjects (Social Research Association, 2003). Ethical considerations intend to promote the interests of the public, and protect them from harm, whilst facilitating and supporting the conduct of high-quality research that is of value to the participants. Consideration should be given to ensuring no harm is imposed upon or towards the participant, and respects the participants right of independence and self determination to take part. This requires gaining fully informed consent, ensuring confidentiality, and providing clarity of the research process. The researcher has a moral obligation that see's all participants are treated fairly, and not perusing one's own interest at the expense of another.

The application of ethical considerations, how they were adhered to and implemented throughout the methodological design and data collection will now be discussed. The research adhered to the Social Research Association and British Society of Gerontology ethical codes of practice (Social Research Association, 2003; British Society of Gerontology, 2012) addressing issues of informed consent, data protection, confidentiality and anonymity, protecting the interests of subjects, their right to withdraw, safety of researchers and disclosure

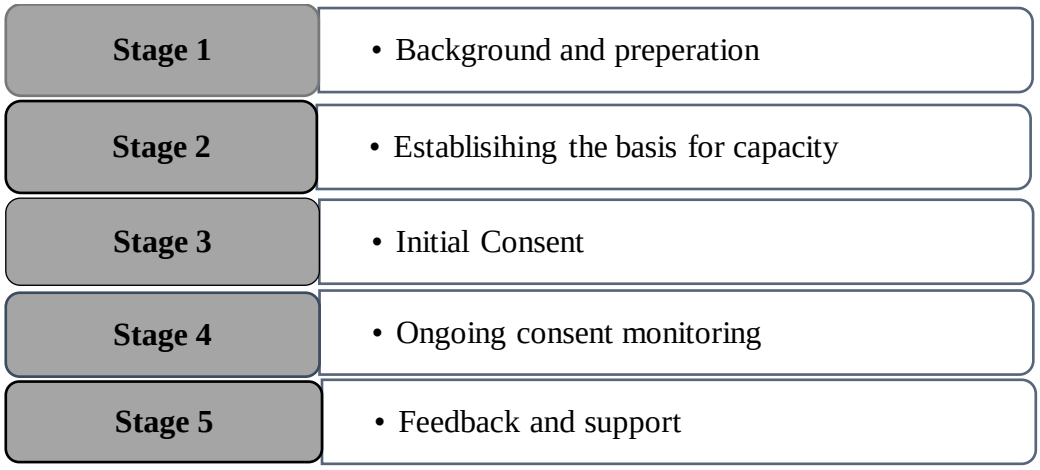
of harm. A favourable opinion from the Social Care Research Ethics Committee was granted on the 4th January, 2019 (See appendix 1). The data collection methods used in this research upheld the dignity of the participants throughout.

Informed Consent

As this research was working with population group where some may lack capacity to consent. A key ethical consideration was to ensure all participants fully understood the implications of taking part in the study and were able to provide informed consent. This research upheld a dynamic approach to the consent process, informed by process consent model originally outlined by (Dewing, 2002). The model outlines five stages which were considered and adhered to when attaining informed ongoing consent from participants within care homes throughout the research process (Figure 9).

Figure 9

The process consent model adapted from Dewing (2002)



The researcher met with the care home team to give background of the research and familiarise themselves with the staff and care home itself. Appropriately formatted information sheets were provided and explained verbally by the researcher to gauge whether they would be interested in taking part in the study. Following the methods used in similar studies, the negotiation of informed consent had several stages, A period of one week was given for participants to decide whether or not they wanted to take part in the study. This enabled and encouraged participants to speak to friends, family and colleagues about their involvement in the study and to ask any further questions. For those unable to read the participant information

form (PIF) or consent forms, the interviewers read out to the information to the participant(s). There were three processes to gaining informed consent from the four participant groups.

Gaining informed consent of Care staff: Once potential participants had been identified and provided with information about the study via information sheets a week prior. The researcher approached the relevant participants at a later date and this time provided them with verbal information about the study. They were asked whether they had any further questions and understood all the information provided in the consent. Only once the researcher was happy that the participant understood and had come under no due pressure to take part did they obtain consent. Consent was on-going throughout the study and participants were asked to consent (with the relevant judgements of capacity made by the trained researcher) at every data collection point beginning with discussion of a written summary of the project and culminating in written or verbal consent at each evaluation point in the study.

Gaining informed consent of older adults: There is a high prevalence of cognitive impairment in care settings. The consent was obtained by the researcher who was fully trained in consent procedures by senior staff in the Centre for Ageing and Dementia Research. Due to the high prevalence of dementia and cognitive impairment in care homes, all researchers followed the regulations and guidance set out in the Mental Capacity Act 2005 which assumes capacity to consent unless found otherwise (see sections 30-34, The Mental Capacity Act, Department of Health, 2005). Other potential barriers considered when gaining consent included the participants communication, physical impairments, frailty and emotional vulnerability. In such cases other verbal or non-verbal cues or behaviours were also considered in the process of consent. The researcher checked that the participant understood the purpose of the study by requesting the participant to recall the information themselves back to the research. Only once the researcher was certain that the older adult completely understood the nature of the study and possible risks associated with their participation, was consent be taken by the Interviewer. Participants that were unable to provide informed consent and participants that consented to take part but failed to meet the inclusion criteria, were excluded from the study but were not excluded from taking part in activities. Consent was also on-going throughout the study and participants will be asked to consent (with the relevant judgements of capacity made) at every data collection point..

Gaining informed consent from younger people: Young people were invited to take part in the intergenerational activities by the school or other group. To obtain consent from children under the age of 18 to take part in research, parental/legal guardian consent was requested via the children's gatekeepers (teachers, group leaders etc). Teachers or group leaders were provided with the parental information sheets and consent forms to be sent to the children's' homes. Only once the parent or guardian had read, agreed, and signed was the younger person considered to take part in the research.

Different consensual processes were applied to two groups of younger participants those aged 5-10 years old and those aged 11-18 years, this was done to take into account their level of capacity to understand information (in the participant information forms) and ability to consent or assent for themselves. Young people aged 11-18 were provided with age-appropriate information via their gate keeper which was read out loud to them at the time of the data collection. Only once the researcher was happy that the child understood fully what was involved was the child asked if they were willing to take part and to provide written consent. An appropriate date to interview the child was organised with involvement of teachers/group leaders. It was made clear to all participants that participation in the research voluntary and they are free to withdraw at any time without explanation and without being disadvantaged in any way. Researchers made it clear that participants were free to ask questions or voice concerns at any stage throughout the study before obtaining additional written consent from the younger participants between ages of 11 and 18.

Young people aged 5-10 were provided with age-appropriate information that was read out loud to them at the time of the data collection. They were asked verbally if they assent to take part in the research at the time of the study, and if so, their assent was witnessed and recorded on the consent form by the researcher.

Personal safety guidelines for researchers and interviewers

The researcher utilised the Centre for Innovative Ageing's lone worker Personal Safety Guidelines and policy to ensure safety. These were required as the researcher might have had to go in the resident's room, or a quiet space in order to conduct the questionnaire or interviews. These made the researcher aware of personal safety in situations which could have left the researcher potentially vulnerable, as participants could pose a potential physical danger to the

researcher, therefore they were informed of these guidelines and actions in order to minimise and potential risks.

Voluntary participation of respondents

The ability for the participant to have choice in whether to take part was made clear throughout. The researcher ensured participants came under no undue pressure to take part in the study should they not wish to. Participants were made aware of their rights to withdraw from the study at any stage should they wish to do so, with the researcher clearly informing them that their withdrawal or refusal to take part in the study would not affect their participation in the activity programme.

Confidentiality and anonymity of data and participants

All data was stored securely in Swansea University, and steps were taken in order to comply with general data protection regulations. All audio devices, paper copies of transcripts and consent forms were kept under lock and key, to which only the researcher had access to, and subsequently scanned digitally as a pdf and stored as password protected computer files. Any paper-based data was shredded and safely disposed of once the data has been transferred to relevant software for analysis. Questionnaires were transferred into SPSS .sav and qualitative data was transcribed onto NVIVO. nvp, both these databases were then stored as password protected computer files. The laptop computer and university computers used in this research were backed up on the shared drive (password protected) for Centre for Innovative Ageing, at Swansea University.

To ensure anonymity; participants' personal information was kept separately from their data. All data obtained were confidential to the study and it was ensured that there would be no possibility of linking any personal/identifying details of any participant back to them. The identity of registered residential or nursing care homes and residents involved in the research was also protected and made anonymous, by coding of names with numbers. Each Participant was assigned an individual identification number that was used in both the quantitative and qualitative data and followed the anonymization protocol for qualitative data transcripts. This permitted the retention of important contextual information without compromising the identity of the individual or care home.

Participant behaviour and disclosure of harm

Participants may become upset, anxious, or frustrated during the questioning. Interviews and questionnaires distributed to younger people, older residents and care staff covering potentially sensitive topics such as loneliness, depressive symptoms, job satisfaction and obtaining information from younger people of grandparents who might have deceased. Further to this, behaviour of residents with dementia may alter quickly, and there is potential of them being confused or distressed (Stokes, 2017). In the event that a participant might have become upset or anxious all interviewers were advised to take extra care and remain empathetic when conducting interviews by providing reassurance and using distraction and mood lifting techniques. The researchers were briefed to suggest a break or a reschedule of an interview if the participant is in any way distressed or uncomfortable, in order to minimise any emotional harm to each interviewee. Additionally, the researchers were briefed to remind each participant of the option to withdraw from the study. It was possible that an individual might reveal abuse in the care setting. All researchers were provided with disclosure of harm or abuse training and were aware of the protocol before commencing data collection within the care homes.

Researcher eligibility

To confirm eligibility of the researcher to conduct research with vulnerable individuals in this study, a criminal record check with the Disclosure and Barring Service (DBS) was required and presented to care home managers and appropriate school representatives prior to commencing any data collection.

5.6. Chapter Summary

In summary, chapter five has described the application and implementation of the mixed method quasi experimental approach used in this study. The chapter described the processes conducted across the five phases of this research study. A combination of quantitative standardised questionnaires, intervention feedback questionnaires, semi structured interview and facilitator field notes were utilised to capture information for both summative and process evaluations of IAP compared to regular activity programmes. Each of these were discussed in detail and how they were implemented with each stakeholder group. It also outlined the data collection procedures, various ethical implications and analytic procedures that were used to analyse findings reported in chapter six.

6. Chapter Six – Results

This chapter presents the findings from the evaluation of nine intergenerational activity programmes run and seven non-intergenerational activity programmes in residential and nursing care homes across South Wales between January 2019 and January 2020. Initial descriptive statistics of the participants included in this study are detailed. Quantitative findings from the summative outcome measures, these are grouped by stakeholder group. Process evaluation findings from thematic analysis are then introduced, these are grouped by key themes around implementation of the activity programmes and mechanisms of impact.

6.5. Descriptive Statistics

All screening and demographic variables were normally distributed, with no significant differences between any of the descriptive statistic variables at baseline for any of the participant groups. Table 17 highlights the distribution of normality scores and AIC scores of the unstructured variance matrices used in the analysis.

Table 17

Distribution of normality scores and AIC scores

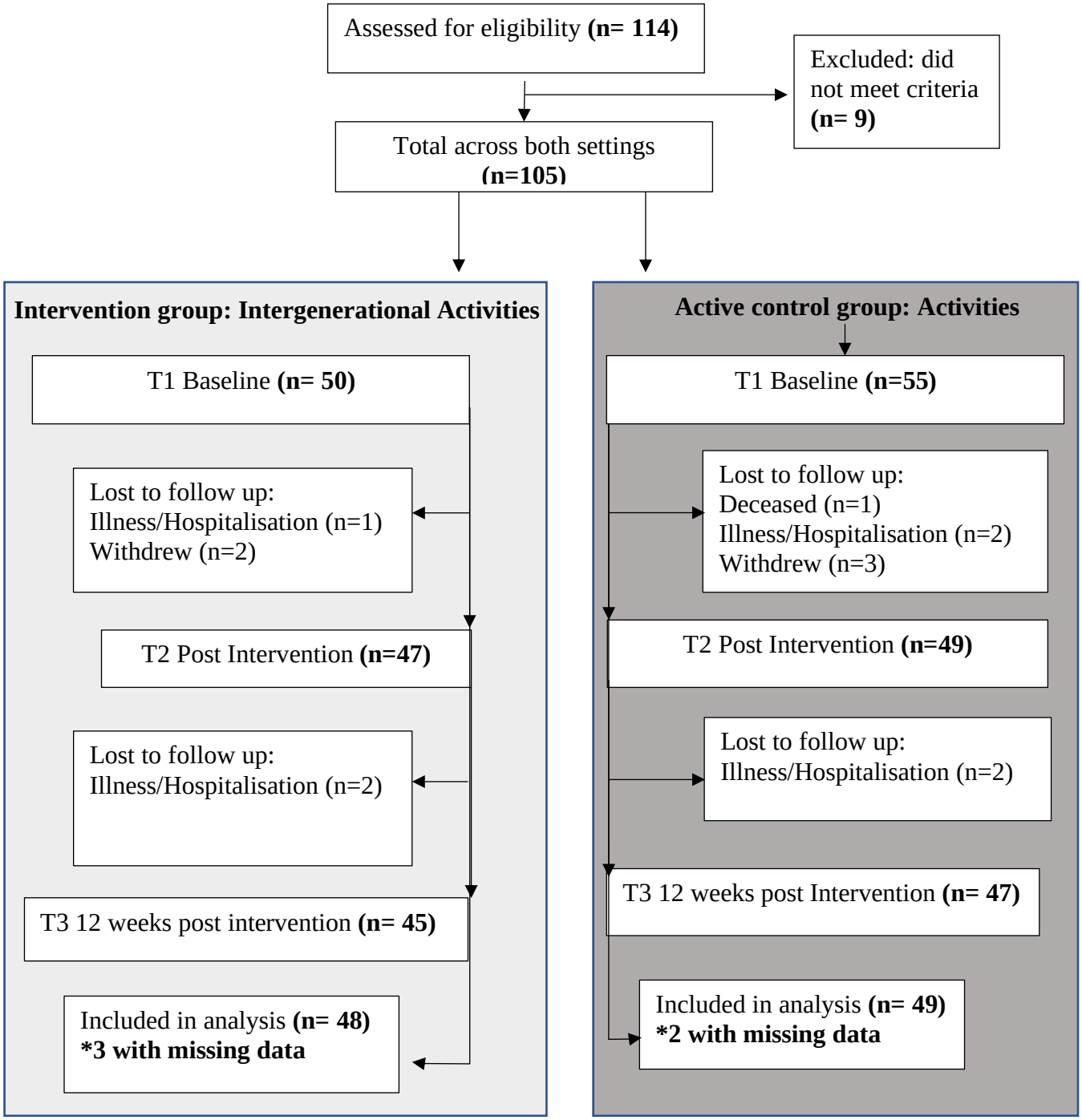
	n	Z Skewness	Z Kurtosis	AIC Scores (Unstructured)
DEMQOL	270	-.087/ .148 = -0.59	-.078/.295 = -0.26	1202.283
EMAS	270	.349/.148 = 2.36	1.036/.295 = 3.51	1375.436
GDS	270	.133/.148 = 0.89	-.837/.281 = -2.31	1327.811
SAHS	270	.013/.148 = 0.09	-.444/.295 = -1.51	584.823
LONE	270	-.086/.148 = -0.46	-1.052/.281 = -3.21	1063.442
JOB SAT	146	-.296/ .201 = -1.47	-.448/.399 = -1.12	1227.351
CWEQ	146	.152/ .201 = 0.76	-.885/.399 = -2.22	881.595
ADQ (CS)	146	-1.003/ .201 = -4.99	.514/.399 =1.29	831.396
STRAIN	146	.867/ .201 = 4.31	.062 /.400 = 0.15	828.615
CATE	288	.006/ .144 = 0.042	.144 /.287= 0.51	1247.839

Older Adults

A total of one hundred and fourteen participants were assessed in ordered to determine their eligibility to take part in this research (Figure 10). Out of these, nine were excluded from the study as they did not meet the inclusion criteria for the following reasons; Age (n=3), MoCA score less than ten (n=4), unable to understand verbal English due to hearing problems (n=2).

Figure 10

Older adult participants inclusion flow chart



Five OA participants withdrew, one deceased following baseline data collection and 3 had illness or were hospitalised so unable to complete the T2 questionnaire. A further 4 were unable to complete questionnaires at T3 due to illness. Of the 7 that missed completing a questionnaire at either T2 or T3 and had missing data, 5 had data for two timepoints and were therefore included in the study. Characteristics of the ninety-seven older adult participants included at baseline are presented in Table 18.

The mean age of older participants was 86 years old, mean age of older adults was slightly higher in the non-IG setting. Ages range from 65 to 97 in the IG settings and from 69 to 96 in the non-IG settings. The majority of OA were white British women. The total scores from each screening measure were assigned labels of low (18-20), Mild (12-17), and High dependency (0-11), and either severe (<10), Moderate (10-17), Mild (18 – 25) or No (26 – 30) cognitive impairment across both intergenerational and non-intergenerational groups. Initial matching of older adult residents was conducted by entering of MoCA and ADL scores into SPSS in order to obtain total scores. The baseline mean scores of MOCA in the IG and non- IG settings were 17.27 (SD = 4.66) and 16.75 (SD = 4.56) respectively. Baseline scores of ADL in the IG and non- IG settings were 13.49 (SD = 4.64) and 14.71 (SD = 4.38) respectively. These were entered into an excel spreadsheet, cross referenced and matched manually. These results suggest that participants included in this study were mostly independent in basic self-care activities but required supervision and assistance when performing complex activities of daily living such as meal preparation and taking medication.

A total of 94.82% of those participated in the study experienced mild to moderate forms of dementia. A one-way ANOVA revealed no significant difference between settings on MoCA $F(1, 96)=1.26$, $p=.265$ or ADL $F(1, 96)=1.77$, $p=.187$.

Table 18

Demographic characteristics (DC) of older participants in the total sample (n=97),

Screening and DCs		IG (n = 48)		Non – IG (n=49)		Total Sample (n=97)		Test for significance
		n	*%*	*n*	*%*	*n*	*%*	
Gender	Men	8	16.7	13	26.5	21	21.6	$\chi2 = 1.391, p = .238$
	Women	40	83.3	36	73.5	76	78.4	
Ethnicity	White British	47	97.9	48	98	95	97.9	$\chi2 = 2.000, p = .368$
	Mixed/Multiple Ethic groups	1	2.1	0	0	1	1	
	Black/ African/ Caribbean	0	0	1	2	1	1	
Marital Status	Single	8	16.7	7	14.3	15	15	$\chi2 = 2.731, p = .604$
	Married	3	6.3	1	4.9	4	4.1	
	Co habiting	3	6.3	6	12.2	9	9.3	
	Widowed	28	58.3	26	56	54	55.7	
	Divorced	6	12.5	9	18.4	15	15.5	
Education	Degree or Equivalent	1	2.1	2	4	3	3.1	$U = 946.5, p = .088$
	A level or Equivalent	3	6.3	8	16.3	12	11.3	
	GCSE Grades A*-C or equivalent	8	16.7	9	18.4	17	17.5	
	Other Qualifications							
	No Qualification	17	35.4	15	30.61	32	33.0	
Length of Stay	< 1 month	2	2.1	2	4	4	4.1	$F(1,95) = 3.048, p=.084$
	1-6 months	6	12.5	11	22.5	17	17.5	
	6-12 months	10	20.8	14	28.6	24	24.7	
	12-18 months	7	14.6	7	14.3	14	14.4	
	18-24 months	8	16.7	5	10.2	13	13.4	
	> 2 years	15	31.25	10	20.4	25	25.8	
Screen: MoCA	None	1	2.1	4	8.2	5	5.15	$U = 1021.0, p = .262$
	Mild	15	31.25	18	3.67	33	34.02	
	Moderate	32	66.7	27	55.1	59	60.82	
	Server	0	0	0	0	0	0	
Screen: ADL	Low dependency	14	29.2	10	20.4	24	24.74	$U = 984.00, p = .164$
	Mild dependency	20	41.7	24	49	44	45.36	
	High dependency	9	18.6	10	20.4	29	29.9	

intergenerational practice group (n=48), and active control group (n=49).

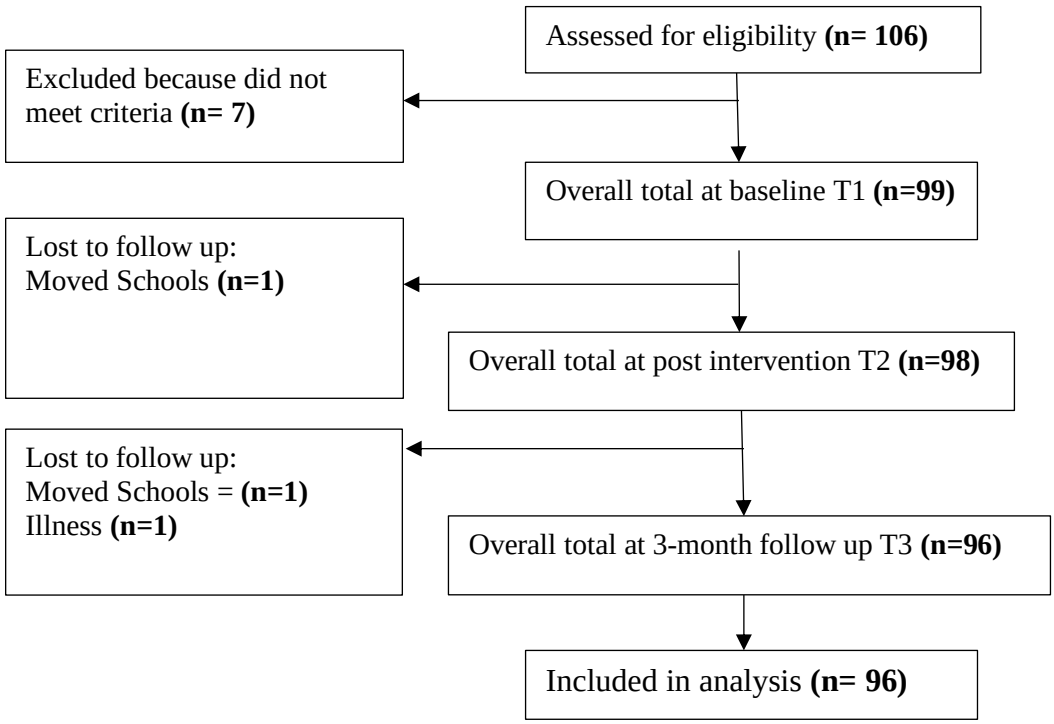
Note. Participants were on average 86 years old (SD = 6.71), *U – Mann Whitney U test, $\chi2$ – Pearson Chi-Square, F= One way ANOVA

Younger people

A total of ninety-six younger people were included in the analyses (Figure 11), three were excluded due to incomplete data sets because of participants moving schools and illness.

Figure 11

Younger participants inclusion flow chart



The age of the younger participants ranged from five to seventeen and was made up of 50 females (50.5%) and 49 males (49.5%) from ten different primary and secondary schools across South Wales. Of these 83% had never visited a care home prior to baseline, and 96% had grandparents alive. From this percentage of participants, just over half saw their grandparents on a weekly basis (51.5%), with 25.3% seeing their grandparents on a daily basis and 22.2% on a monthly basis, one participant responded to this an not applicable.

Care staff

Fifty-eight care staff were assessed for inclusion in the study, two were unable to take part as they did not provide informed consent. Overall a total of fifty-three care staff across both settings; intervention (n=32) and control (n=21), completed self-questionnaires. Demographic characteristics are presented in table 19.

Table 19

Demographic characteristics of care staff in the total sample (n=53), intergenerational practice group (n=32), and active control group (n=21).

Descriptive variables		IG (n = 32)		Non – IG (n=21)		Total Sample (n=53)		Test for significance
		n	*%*	*n*	*%*	*n*	*%*	
Gender	Men	3	9.4	5	23.8	8	15.1	$\chi2 = 2.061$,
	Women	29	90.6	16	76.2	45	84.9	$p = .151$
Ethnicity	White British	31	96.9	18	85.7	49	92.5	$\chi2 = 2.612$,
	Mixed/Multiple Ethic groups	1	3.1	2	9.5	3	5.7	$p = .271$
Marital Status	Single	11	34.4	8	38.1	19	35.8	$\chi2 = 3.468$,
	Married	17	53.1	9	42.9	26	49.1	$p = .325$
	Divorced	2	6.3	4	19.1	6	11.3	
	Civil Partnership	2	6.3	0	0	2	3.8	
Education	Degree or Equivalent	7	21.9	3	14.3	10	18.9	U = 302.00,
	Higher Education	2	6.3	1	4.8	3	5.7	$p = .525$
	A level or Equivalent	10	31.3	7	33.3	17	32.1	
	GCSE Grades A*-C or equivalent	6	18.8	5	23.8	11	20.8	
	Other Qualifications	6	18.8	4	19.1	10	18.9	
	No Qualification	1	3.1	1	4.8	2	3.8	
Contract Type	Full Time	25	78.1	16	76.2	41	77.4	$\chi2 = 819$,
	Part Time	6	18.8	5	23.8	11	20.8	$p = .664$
	Student	1	3.1	0	0	1	1.9	
Job Title	Care Home Manager	6	18.8	2	9.5	8	15.1	$\chi2 = 4.505$,
	Nurse/Senior Carer	6	18.8	1	4.8	7	13.2	$p = .212$
	Care Assistant	8	25	10	47.6	18	34.0	
	Activity Co-ordinator	12	37.5	8	38.1	20	37.7	
Time in Job	Less than 1 month	4	12.5	2	9.5	6	11.3	$F(5,47) =$
	1-6 months	4	12.5	1	4.8	5	9.4	.724,
	6-12 months	5	15.6	4	19.1	9	17.0	$p=.609$
	12-18 months	1	3.1	3	14.3	4	7.5	
	18-24 months	4	12.5	4	19.1	8	15.1	
	More than 2 years	14	43.8	7	33.3	21	39.6	

In total ninety-seven older adult participants, ninety-six younger people, fifty-three care staff and participated in the study. As part of the process evaluation intervention feedback questionnaires and semi structured qualitative interviews were also conducted (Table 20). A

total of 43 older adults and 32 care staff in the intergenerational setting and 20 and 38 in the non-intergenerational completed the intervention feedback questionnaires (N=52), every younger person completed the intervention feedback questionnaire (n=96). There was a drop in completion rate compared to standardised questions as older adults were tired by the end of the standardised questionnaires and did not want to carry on completing the intervention feedback questions. Some care staff missed the intervention feedback questionnaires. Over all 24 semi structured interviews were completed with older adults and care staff from both settings.

Table 20

Summary of numbers of participants involved in process evaluation data collection methods in each setting

	Intervention feedback questionnaires		Qualitative interviews	
	IG	Non-IG	IG	Non-IG
OA	43	38	8	6
CS	32	20	12	8
YP	86	0	0	0

7. Chapter Seven - Process Evaluation

This section outlines the findings relating to the process evaluation. The analysis of data for the process evaluation has been adapted from the steps suggested by the MRC for complex interventions. When analysing the process evaluation Moore and colleagues outlined key recommendations, the research aimed to fulfil. The following key recommendations were achieved:

- a descriptive quantitative information on fidelity, dose, and reach
- collection and analyse qualitative data iteratively so that themes that emerge in early interviews can be explored in later ones
- ensured the quantitative and qualitative analyses build upon one another
- analysis and reporting of process data before outcomes are known to avoid biased interpretation

The process evaluation utilised five key domains (Table 21) which were explored using qualitative and quantitative data. Across the five key components of the process evaluation, seven key themes emerged as follows (Table 21).

1. Types of activities,
2. Recruitment/Facilitators and barriers to participation
3. Engagement
4. Flexibility and adaptability
5. Significance, experiences, and enthusiasm for activities
6. Intergenerational interactions development of relationships
7. Symbols of meaning

The themes are discussed in relation to components of process evaluation, but also the context (Table 21). Although the context was not discussed explicitly in the qualitative data, elements were drawn out from the data to explain how the contextual facts affected implementation, intervention, mechanisms and outcomes.

Table 21

Components of the process evaluation

Components		Themes	Context
Implementation *(How delivery is achieved)*	Dose delivered	• Types of activities	Planning of activities programme
	Reach	• Recruitment • Facilitators to participation • Barriers to participation	Social and environmental influences
	Fidelity	• Flexibility and adaptability	
Mechanisms of impact (*participants responses and interaction with the intervention, mediators, unexpected pathways and consequences)*		• Significance of activities/ experiences of activities / enthusiasm for activities • Interactions and the development of relationships • Symbols of meaning	Social and environmental influences Care home culture

7.1. Implementation

7.1.1 Dose delivered

All intergenerational programmes intended to run a minimum of eight weekly sessions. These sessions were on top of the traditional activities normally run in the home. Out of the ten intergenerational activity programmes included in this study, two sessions in one of the intergenerational activity programme settings were cancelled due to illness of participants and organisers. As a result, six weekly sessions were run in this care home.

> I think what happened is, obviously one session, the children had a sickness bug so obviously they couldn't come down to the nursing home. And then, I think another session, some of the residents were ill, you know. Which is understandable, isn't it? So, we've had to cancel.
>
> (Care staff, Intergenerational Activity CH, participant 29)

All sessions lasted at least one hour, although some ran a little longer. The mean duration for the intergenerational activity programmes was 1 hour 15 minutes, compared to 1 hour 25 for the non-intergenerational activity programmes mean duration. All but one of the intergenerational sessions lasted 60 minutes, The intergenerational activities were often constrained by the timetabling of the school.

Number of sessions received: Attendance rates for each of the sessions was collected by facility care staff and representatives of the younger people. Intergenerational programmes aimed to run a minimum of eight weekly sessions. Out of the nine intergenerational care homes, eight ran all eight sessions. One care home had to cancel two sessions due to teacher's illness and resident illness. This care home was exclude from the average attendance rates. The average attendance rate of older adults to the intergenerational sessions was 8.86 (SD=2.72) compared to control setting where the average attendance was 6.5 (SD=0.94). Although mean attendance across an 8 week duration of activity programmes was higher in the intergenerational settings, a one way ANOVA revealed this difference was a non-significant difference $F(1,17.63)=3.67$, $p=.075$. The mean attendance for younger people in the intergenerational activity programmes was 9.90 (SD=4.62). Overall, five older adults were reported to have withdrawn and one deceased during the period of the study, another had a minor stroke during the period of the activity programme therefore missed two sessions however the older adult opted to carry on attending despite having had the stroke. A total of 3 younger people withdrew from the study due to moving schools and illness.

The intergenerational element drew residents in, with care staff highlighting they required much less persuading to join in the activities with the children. It appeared that individual's motivation to engage with the activities in the intergenerational settings was greater than that of the non-intergenerational activities.

> Normally I have to fully explain what an activity is to try and persuade the residents to get involved and come. Whereas now with some of the residents, it was simply a case of saying the children are coming at 2 o'clock and they go alright I'll be there, you know they didn't care what the activity was, but the children are coming and that's all they needed to know.
>
> (Care home activities coordinator, Intergenerational Activity CH, participant 21)

In the non-intergenerational sessions, numbers of attendees for each activity varied, with individuals often knowing what to expect from the session and whether they enjoy it. Often the older adults in the non-intergenerational setting would pick and choose the specific activities they attended depending on their personal preference and whether they liked the activity that was being run. For example, the knitting sessions were often only attended by women, this meant certain activities disengaged several residents. As a result, there was differing enthusiasm for specific individuals in relation to the different activities within the non-intergenerational settings. The level of enthusiasm around the activities differed between intergenerational activities and non-intergenerational activities. This enthusiasm of residents to part take in the activities influenced the fidelity of the activity programmes. For example, one older adult in the non-intergenerational activity setting suggested that most of the residents were not enthused to take part in activities generally:

> Whatever the activities are, you've got to have the interest of your people to carry them out, and a lot of people just can't be bothered you know; they sit back and go to sleep, they don't enjoy that.
>
> (Older adult, Non-Intergenerational activity CH, participant 1)

The level of enthusiasm for the activities also stemmed from younger peoples general enthusiasm, for activity co-ordinator mentioned how they came into the room for the activities "It's just the fact that the children are so enthusiastic, they literally were like, running in the doors after the first week like, 'I want to sit by her', and you know, they were so keen to see them" (Care home activities co-ordinator, Intergenerational activity CH, participant 1), another older adult commented on their mannerisms and behaviour "They're so polite, they're so friendly, we love them coming" (Older adult, Intergenerational activity CH, participant 13)

It was noted that in the intergenerational activities programmes the residents who did not normally want to engage took part either straight away or observed from a distance built up engagement slowly.

> I've noticed now that at every session more and more residents are coming to see what is happening and what's going on. For example one guy looked and asked what we were doing and asked if he could join in. Another lady was walking round but doesn't

> come to many activities yet she came and asked what we were doing and sat down with the children, had a chat and they gave her a pencil and she started colouring in so I guess it's a slower process of engagement for some
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 61)

Residents in the non-intergenerational settings also tended took to observing the activities, demonstrated by the following quote "We have quite a lot of residents as well who like to just come and watch, even though they don't want to physically participate they join in conversations, or if they can't join in conversation I know they sit and they watch and listen" *(*Care home activities co-ordinator, Non-Intergenerational activity CH, participant 49)

Observation of non-intergenerational activities did not seem to motivate or lead to participation. Activities in the non-intergenerational activity programme did engage residents, however there seemed to be a noticeable reduction in with which they expressed enthusiasm for the activities compared to the intergenerational activity programme, with some older adults stating "I can't be bothered now because I'm not up to it" (Older adult, Non-Intergenerational activity CH, participant 102). Participants described the intergenerational activities as the *"*the one activity I wouldn't miss*"* (Older adult, Intergenerational activity CH, participant 33), and in one home the activity co-ordinators suggested that the activities with the children was the most popular activity with the older adults stating it was *"*the thing they look forward to the most" (Care home activity co-ordinator, Intergenerational activity CH, participant 70). This was in contrast with non-intergenerational settings where care staff often spoke of the struggle to get residents to engage with the activities and drum up interest:

> Some residents don't participate. One of my hardest jobs here is trying to get them to participate, you've got to proper nag them sometimes, "please come along, just try it, if you don't like it you don't have to come again", but it's the initial trying to get them to carry out an activity that they've never done before, that's probably the hardest.
>
> (Care home activities coordinator, Non- Intergenerational activity CH, participant 2)

There seemed to be a division of activity provisions for those with dementia, one care staff explained:

> Everyone's needs are different. Some things you can do together, even if it's just painting a picture, but other things then you can't, so it's different abilities, you've got all the people with dementia and it's different types of dementia
>
> (Older adult, Non- Intergenerational activity CH, participant 110)

7.1.2. Types of activities

Both the intergenerational and non-intergenerational activity programmes consisted of very similar types of activities. The types of activities delivered within the activity programme fell under seven general themes; Music, gardening, games and quizzes, technology, church, arts and crafts, physical exercise. The types of different activities run in each setting are highlighted in Table 22.

Table 22

Types of activities in each setting

	Non Intergenerational Activities	Intergenerational Activities
Music	Yes	Yes
Gardening	No	Yes
Games and quizzes	Yes	Yes
Technology	Yes	Yes
Church	Yes	No
Arts and crafts	Yes	Yes
Physical exercise	Yes	Yes

Music

Non intergenerational settings: Music was based around playing of instruments such as drums and tambourines as well as the majority of care homes having external professional singers come into the home and sing to the residents.

Intergenerational settings: Children and residents sang songs together with the children and older adults deciding between them what songs they wanted to sing, including old Welsh

hymns the teachers had taught the children prior to coming to the home. Some sessions saw the residents and children playing instruments such as the drums, tambourines and maracas, where the instruments were swapped between songs.

Games and exercise

Non intergenerational settings: External individuals from different organisations led exercise classes for the residents, such as Zumba and chair exercises. Residents appreciated the opportunity to take part in exercise and recognised their importance. All had quizzes, and bingo.
Intergenerational settings: Participation in joint games activities such as board games, pub quizzes, bingo, guess the object, parachute, balloon tennis, and skittles that required team-work, social interaction, and eye-hand coordination. One care home activity co-ordinator created their own game, using a sock with an object in, the residents and the younger people had to try and work out what it was by sticking their hand in the sock and feeling it by touch. Some of the objects were from when the residents were children and they then explained what they were and how they used them.

Technology

Non intergenerational settings: In one care home they had a sensory 'time tablet' which is an interactive touch tablet: residents could interact in games and moving images, such as fish swimming on the screen. Younger people and residents worked together to catch the fish and get as many points as possible.
Intergenerational settings: In a specific intergenerational programme, children were trained by external organisation to use and teach older people to use IPads prior to vising the care home. Children showed the residents how to use YouTube, find the weather, and use Google. These technology-based sessions undertook the similar activities every week, albeit with a slightly different focus. One care home had a new sensory technological device called the OMi-Vista, which both younger and older participants used to interact via interactive games and quizzes, sensory scenes and sounds from nature, and nostalgic themes and music. This provided physical and emotional stimulation. Time tablet was also used in some of the sessions in the intergenerational activities.

Arts and Crafts

Non intergenerational settings: One care home had an external facilitator to come in a run 'Creating Mojo' an arts and craft session. Other arts and crafts also included knitting, flower

arranging, crocheting, baking, and candy floss making. Some of the arts and crafts activities were featured around or focused on preparation for the day of celebration such as Valentine's day and Christmas.

Intergenerational settings: Participants were involved in the creation of specific end products such as papier mache, play dough, stained glass windows, cards and portraits of each other. Cards were created by the younger people, with drawings of the residents included in them and heartfelt messages of how they have enjoyed the sessions.

Gardening

Non intergenerational settings: No gardening activities were reported, although residents spent time outside in the outside gardens and courtyards on occasions.

Intergenerational settings: Jointly potting seeds, plants and vegetables and harvesting them. Some planted flowers in raised bed with the children and older adults working together to select when the plants should go and what types of plants looked good together. Once they decided where the plants should go, the children were tasked with handing out the equipment such as gloves and gardening tools to the older adults. the children and residents jointly dug holes and placed the plants in them. This involved team work and communication. They also created name tags for the plants so they knew what the plants were.

Church service

Non intergenerational settings: Individuals from the local church performing a church service within the care home.

Intergenerational settings: Not applicable. The children did not engage in any church services.

Apart from the digital technology activity programmes, the types of activities run each week varied, as one activity co-ordinator explained:

> So, each week, I've planned it, we've taken any equipment we've needed… we've done art, we've done like, a board game day where they all play board games. We did a sort of, quiz word game type one, thinking of animals that begin with each letter of the alphabet, and just things they can do with each other. So, we've tried to sort of, vary it.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 57)

In contrast, the non-intergenerational activities tended to have the same two or three activities each week. Most were traditional care home activities such as quizzes, exercise, bingo, singers, as one activity co-ordinator explained:

> We have set activities every week, so like Wednesday afternoon is church service, that's a big turnout for us, every Friday we have a singer and Monday morning exercise class, and Monday afternoon is quiz, so yeah we have lots of activities.
> (Care home activities co-ordinator, Non-Intergenerational activity CH, participant 163)

Most care homes has activities on set days, in order that older adults are able to associate certain days with certain activities. However, many of the older adults and care staff talked about the children breaking this cycle of repetition of routine activities, enabling care staff to run new activities ideas and bringing new experiences laughter and silliness into the care home and brining a change of atmosphere to the intergenerational settings. This was demonstrated in the following quote from an activity co-ordinator "It's easier for us as well, because we can now do new activities with them as well, instead of just routine stuff. This was new. and, every week, the kids were showing them different things" (Care home activities co-ordinator, Intergenerational activity CH, participant 48*).*

The types of activities included in the intergenerational activity programmes introduced intergenerational socialisation and interaction between younger people age 18 and under and older adults age 65 and over living in residential or nursing homes. The older adults were under the responsibility of the care staff within the care home and the younger people were under the responsibility of the school teaching staff. In one of the intergenerational activities programmes the children were volunteers from the charity Mind and under the responsibility of the mind representative who was responsible for organising the programme. In two of the intergenerational programmes external facilitators were involved, their role was specifically to organise, plan and deliver the sessions in collaboration with the care home and younger people facilitators. They had received funding from charities and third sector organisations to run these projects.

The sessions in all of the non-intergenerational settings were planned by the activities co-ordinators in the home. Some had external people come in such as solo singers and individuals running exercise classes such as Zumba and chair exercises. In contrast either care staff (such

as the activity facilitator) or teachers designed the intergenerational activity programmes. All activity programmes both intergenerational and non-intergenerational took place on the care home premises. None of the activities took participants off-site. The activities were carried out either in the main communal spaces of the care home or outside but within the care home grounds.

The bigger care homes were able to provide much more in terms of activities they ran. The larger care homes seemed to have more resources to put into activities than the smaller care homes. In the larger facilities activities were often considered as a 'selling point' for future residents. The unintended consequences of differences between care homes in the level of resources that they could draw upon, increased the competition between care homes. Smaller care homes felt an added sense of pressure associated with this.

> When you've got activities in a care home where there's a chain of care homes, it's all pressure for social media and all competitiveness between care homes. What that does, because they're so competitive it puts pressure on the residents you know, so. I think it does make you do better, and I think the end consequence is that you do actually do better, because you feel you've got to meet other peoples' standards, but it also puts more pressure on that person, and it makes your job not as enjoyable, because like now you can tell I'm quite stressed today.
>
> (Care home activities co-ordinator, Non-Intergenerational activity CH, participant 163)

In all the intergenerational settings the content of the sessions were developed collaboratively between the care home facilitators and individuals representing the younger people. However, in most programmes one representative, either from the school or care home, took greater ownership of the activities than the other. The organisation from which the individual who took greater ownership varied between the intergenerational programmes. For example, teacher explained that she came up with ideas and then took these to the care staff in order to see if they were appropriate.

> I met with the staff at the care home just to say, 'this is what I'm thinking of doing, is that feasible?'. Because, obviously I know what my children can do, whereas you might think, the residents, they're older, that might be too young for them, actually. I think they're kind of, at the same level almost, of what they enjoy.

(Facilitator, Intergenerational activity CH, participant 70)

When developing the content of the sessions for the intergenerational activities programme, many of the facilitators looked online for inspiration in relation to types of activities they could do, as explained by one of the care staff:

> I looked online because they have sort of, other stuff from previous projects. I think it might have even been an American one, but it was like, a big thing of intergenerational activities. I sort of, took some and tweaked them a little bit.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 21)

Other facilitators such as activity co-ordinators drew on their expertise at delivering activities and tended to adapt the activities they typically did with older adults.

> I was the main person in terms of organising all of them, I planned it all to start with and took a plan to the school before they started so that they could check it was appropriate for the children and give their input. It meant everyone knew what was going on as well children as well of course.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 122)

It was often the individual that displayed greatest enthusiasm and passion for intergenerational activities that acted as a driver in the and delivery of the activities. This was highlighted by one of the care home managers when speaking about her activity co-ordinator "Luckily, [name of activity coordinator] is here. Because, I don't think all nursing homes have got Rachel, that's the difference. And, that would be hard then" (Care home manger, Intergenerational Activity CH, participant 8)

7.1.3. Reach

In both settings the recruitment of older adults to participate in activities was conducted by the care home activity co-ordinator or team. The recruitment processes for the activities took a similar course in all care homes included in this study; activities for the week were posted on message boards in the care homes and/or activity leaflets were left with the resident each week.

In addition to this, care staff and activity co-ordinators used word of mouth to inform residents about the activities happening that week and to see if they wanted to join in.

Schools used a variety of selection methods when recruiting younger people to take part in the activities. Some schools took whole classes, other schools had classes of younger people from which the ones who displayed behavioural issues in lessons were chosen. Other schools pre-selected the children based on who they believed would benefit the most and accounting for different personalities in terms of communicating with the older adults and being able to cope in a new environment. For example, one teacher noted that taking a selective approach was key in terms of ensuring engagement and interaction between the participants.

> We've got to choose the right children. In a lot of programmes, it might be we're choosing children to build their self-esteem and confidence, or physical development. For this, we have to choose the right children that we knew had the social skills, that would interact with the residents. There would be no point taking 10 children down there, who are going to be silent.
>
> (Facilitator, Intergenerational Activity CH, participant 70)

This selection method was based on certain characteristics and an underlying theoretical position of the facilitator that intergenerational activities would have a greater positive effect on some children than others, such as developing social skills for children who lack them. Therefore the way the children presented themselves to the facilitators seemed to impact upon recruitment. In contrast to this, the schools that took a more holistic approach had greater variation in personalities of the younger individuals who participated. This difference was personalities also picked up on by one of the older adults in the intergenerational settings:

> It all depends on the children. Some are full of beans, others are shy so it's very difficult to say that they are all the same, because they vary you can pick out the shy one and get them involved too.
>
> (Care home activity co-ordinator, Intergenerational Activity CH, participant 21)

The same children attended each session of the intergenerational programmes, this allowed for the development of friendships between participants, and enticed individuals to attend more sessions.

7.1.5. Facilitators to participation in activities

Recruitment to intergenerational activities seemed less arduous than getting residents to non-intergenerational activities. Care staff in the non-intergenerational settings highlighted issues around '*rallying up'* individuals for the activity sessions, with there being greater unpredictability in terms of how many people would join and engage with the non-intergenerational activities, as one activity co-ordinator explained:

> It very much depends on the day, on how people are feeling… you could do an activity which you have spent weeks planning and you've put as much effort and really excited, and think, 'they're going to love it', and you do it and no-one enjoys it, everyone thinks it's awful and they want to go back and watch the TV.
>
> (Care home activities co-ordinator, Non-Intergenerational Activity CH, participant 140)

Across the settings, ultimately it was the personal choice of the resident to attend activities. However, it seemed greater encouragement from staff was needed to get the residents involved in the non-intergenerational activities.

> It's about encouraging them when they don't want to do it, but they also are allowed to say no. Like if I say to someone*, "would you like to come and do this with me*?", and they say, *"no", we don't say, "alright then",* we just, there's a fine line between giving them a choice and encouraging them to join in, because if they say no they say no every single day.
>
> (Care home activities co-ordinator, Non-Intergenerational Activity CH, participant 120)

It was apparent in the intergenerational activity settings older adults felt an emotional tie to the activities with the children. As a result older adults made more of an effort to attend these sessions each week, even if they were not in the best mood prior to the activities.

> I definitely feel like, more so with the children than other activities, it's like putting on a happy face. Even when you've not really been in the right mindset like, going into it, as soon as the children arrive, it's all smiles. And, I think, you know, being around such

> lively characters and like, it sort of adds a bit of spirit into here. And at the end of it, everyone is in such a great mood.
>
> (Care home activities co-ordinator, Intergenerational Activity CH, participant 61)

There was repeated references to 'clear joy' on the residents faces when the younger people were present, especially amongst those who show little signs of enthusiasm or excitement towards things. Additionally, some residents who did not regularly attend activities, surprised other residents and care staff by attending. One manager explained:

> There was a session with a particular resident where she can often be quite negative with things but every time I looked at her in this particular session she was just beaming, you couldn't wipe the smile off her face. I mean the biggest smile, she doesn't come to many of the activities it's really hard to engage her so it was in usual for her to have that reaction to the children
>
> (Care home Manager, Intergenerational Activity CH, participant 152)

A change in behaviour was highlighted frequently by care staff in relation to residents coming out of their rooms and engaging in activities, something they would not normally do.

> She used to have a very solemn face and not interact but then as soon as the children come in his face would beam, Until the time she went back to her room her face would be really, really, happy. Yes she changed like a match it was beautiful.
>
> (Care home activities co-ordinator, Intergenerational Activity CH, participant 86)

The intergenerational activities also impacted on the behaviour of younger participants. Participants displayed different aspects of their characters that staff had not seen before. For example, speaking about one of the children, one facilitator explained:

> One of the boys was playing draughts with one of them… He obviously plays it at home and he doesn't really talk much in class. But, I've heard him talk more in three weeks at the care home, than I've heard him talk all year. He was like a totally different boy. So, that was really interesting to see, that he's quite happy talking to an 80 year-old man about how to play draughts, and talking strategy and everything. Yet, in class, you never hear a peep from him.

(Care staff, Intergenerational Activity CH, participant 76)

In the intergenerational settings there were many examples of how older adults started to change their behaviours towards to younger people, as explained by one activity co-ordinator:

> He's [older adult] never had children so obviously he's never had the opportunity of having grandchildren. He was a bit stand offish the first day but then he'd come down and have a little look. Then he would sit down with them, then he would sit down with them and start drawing the boys.
>
> (Care home activities co-ordinator, Intergenerational Activity CH 122)

The intergenerational activities also enabled staff to get to know the residents more, when engaging with the children the residents opened up a lot about their past sharing stories with the children. There were a number of examples reported by care staff in which they found out things the residents did, or were good at, that they had not previously known.

> Her [older adult] job was a main toy buyer for [Large toy store]. Children isn't it. So it's a massive outcome for her to be involved with those kids. Massive. I didn't know it, this has all come out. This helps bring those things out and to understand why [older adult] was so excited and so happy to do that. [Older adult] as well, I didn't realise he could draw so well. The boys were sitting there, and he was drawing a silhouette of them. We have definitely learnt more about the residents
>
> (Care home manger, Intergenerational Activity CH, participant 152)

Although many of the facilitators spoke of the natural flow of interactions within the sessions, some facilitation was needed to encourage and promote intergenerational interactions.

> I would try and facilitate it. You have got to facilitate it. I have to be honest, my first thought was 'ah how is this going to work'… But it was so natural, it was easy to facilitate, it was not a problem at all. The benefits absolutely outweighed anything that I had to do, which was very minimal to get that to work.
>
> (Care home activities co-ordinator, Intergenerational Activity CH, participant 21)

Throughout the course of the activities care staff engaged in informal conversations with the residents about the sessions with the younger people. In these conversations older adults often discussed the activities with the children from the previous week, recalling their experiences and what they enjoyed from the last session. These informal conversations also enabled care staff to remind them of when the younger people were next coming in as one care home manager explained:

> They're always looking forward to it. They always ask, 'when are the children coming back again?', so I have to tell them like, 'they will do it every Wednesday, every week, they will come'. So, there is something that they look forward to, every Wednesday.
>
> (Care home activities co-ordinator, Intergenerational Activity CH, participant 57)

Another activity co-ordinator had similar conversations with residents:

> Reminding them that they're coming in, and just having that conversation through the week of like, what was happening, when you go into their rooms. It's definitely a hot topic of conversation with all the staff here and myself… it's the thing that's the most popular and the thing they look forward to the most.
>
> (Care home activities co-ordinator, Intergenerational Activity CH, participant 61)

There was an element of surprise from the care staff in relation to how well the residents remembered the names of the younger people, for example one activity co-ordinator commented "Like, the memory of sessions, what they did. You know, again, names of children. Yeah, even conversations they had with children. Things that I, with certain residents, maybe underestimate" (Care home activities co-ordinator, Intergenerational Activity CH, participant 21). Similarly another commented, "And, the same with the residents, you know, remembering names and things. Things like that, almost surprised me that some of them were remembering the children's names" (Care home activities co-ordinator, Intergenerational Activity CH, participant 80)

Semi structured interviews with older adults suggested one of the primary motivators to regularly attend sessions was the sense of fun and life the younger people bought to the care home. Nearly all older adults (94%) involved in the intergenerational activity indicated that the

activities lifted the atmosphere and spirit of the care home. Care home staff noted that even individuals with more severe cognitive impairment also demonstrated excitement and anticipation of the arrival of children to the care home.

> The pure delight on her face when she sees the children, she can't smile any harder. Honest to God she was like beaming, waiting for them, and as soon as she sees them she goes into the entrance and she's pulling and holding the kids, and holding their hands. It's absolutely wonderful! It's wonderful.
>
> Care home activities co-ordinator, Intergenerational Activity CH, participant 151)

This anticipation and excitement around the intergenerational activities was also apparent amongst the younger individuals. For example, one teacher described the excitement of the younger people on the bus en route to the care home:

> The bus, even though it's like, a two-minute bus journey, the noise level on the bus. You'd think you were taking them to like, a party or Macdonald's, or the traditional things you'd expect children to get excited about. You maybe wouldn't think, 'oh, a trip to the local care home', is going to get them that excited… I had to keep turning around and being like, 'stop screaming', and then like, 'right, we're going in the care home now, you need to calm down', because otherwise they would have just gone running in there like.
>
> (Facilitator, Intergenerational activity Care Home 70)

A few care homes provided opportunities for the residents to say what they would like to do in the activities, as one activities co-ordinated explained

> I've gone around every resident about seven times, saying like, 'is there an activity you would like to do?'… And, a lot of them was, like we had a few of them … saying, 'well, I'd like to work and have the kids visit us more, and doing anything, but just visit us more.
>
> (Care home activities co-ordinator, Intergenerational activity CH 122)

From the quote above it is apparent there was a desire for interaction with children, and this was reflected in the reported ease of getting older adults to engage with the activities, something

that differed between settings. While a select few might have been interested in specific activities run in the non-intergenerational activity programme such as knitting or a church service, the one older adult explained that the intergenerational activities tended to be for the many not the few. The intergenerational element drew in a lot of residents, and care staff noted that they required much less persuading to join in the activities with children.

> Normally I have to fully explain what an activity is to try and persuade the residents to get involved and come. Whereas now with some of the residents, it was simply a case of saying the children are coming at 2 o'clock and they go alrigh I'll be there, you know they didn't care what the activity was but the children are coming and that's all they needed to know.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 35)

Giving the residents the choice to engage was key, although this study was unable to capture whether everyone in the care home was informed of the activities that were planned.

> It is tailoring the activities to meet the needs of the residents not just the children but then you have to think that not every resident wants. To see the children it's just been able to give them the option and most people do take up the option to engage when children are here.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 21)

The selection of younger people to participate took different approaches, there was an underlying theory on behalf of the teachers on what the intergenerational activities would achieve. One approach was based more on the individual characteristics and personalities of the younger people. With this approach it appeared that facilitators were the intergenerational activities from a more older adult perspective, choosing people who had certain social skills that would interact well with the older adults. In contrast, some younger people were selected based on an a 'underlying theoretical position' that intergenerational activities would have a greater positive effect on some children than others, thinking more about developing social skills for children who might lack them. Others used a random selection, which included a group of younger participants that had a mix of personalities, including those that were shy.

7.1.6. Barriers to participation in activities

One of the main barriers to maintaining consistent participation in both settings were health issues. Other influences such as visitors, health appointments, and residents having second thoughts about taking part were also factors that affected participation in both settings.

A factor that influences equal participation in activities was level of cognitive impairment. In the non-intergenerational activities residents with more severe dementia were described as disruptive by care staff and residents. Some residents in the non-intergenerational settings expressed feelings of frustration towards other residents and consequently put other residents off coming to the activities. As a result, care staff expressed the need to separate out older adults with behavioural and psychological symptoms of dementia (BPSD). The care staff carried out different activities with these individuals, in order to meet the needs of both older adults both with and without dementia.

> We don't like doing it but unfortunately, we have ladies and gentlemen with dementia who do very repetitive things, such as banging the table, or keep saying the same question over and over again. And a lot of the other ladies and gentleman who haven't got dementia, can't handle it. They say, 'I've got to go back, take me out' type thing. So we try and do, we call it the butterfly club, because in place now we put butterflies on the folders which give all the staff, yes this lady or gentleman has dementia, so you would take more time to speak to them, give them more time to answer. A lot of things like that, so we try to do a club focused more that way.
>
> (Care home activities co-ordinator, Non-intergenerational activity CH, participant 2)

Whilst this was not seen as something they would do out of choice and was not the case all of the time, this particular lens on BPSD and the subsequent separation may be a sign that the staff are not really getting to the root cause of the behaviour. However, in the intergenerational settings staff reported that these behaviours were not so apparent and having children around seemed to put people at ease and reduce the amount of disruptive behaviours that they sometimes displayed during participation in activities.

In the intergenerational settings some staff did express initial concerns over the unpredictable and disruptive nature of the older adults with behaviours often associated with dementia, such

as agitation and confusion. Any concerns about older adults with dementia seemed to dissipate quite quickly once the sessions were up and running. It was frequently reported that behaviours were much calmer and less disruptive than normal for certain individuals.

> We've got some residents with dementia that can be quite restless and shout out. And, that was my concern, I didn't want any of the children to be frightened of them... But actually, to see what a calming effect they've had. There's two residents in my mind when I talk about this... but they were so calm throughout all of the sessions. They didn't shout out once, they weren't restless or agitated. They were just sort of absorbing in everything that was going on around them... it was really positive thing to see, and it reassured me going forward.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 122)

Another activity co-ordinator reported similar experiences with an older adult who also had dementia.

> She [Resident with dementia] sometimes can be very moody and unpredictable, she thinks we are going to throw out of the wheelchair and stuff like that, but we had none of that when she was engaged in the activities with the children.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 61)

The presence of the younger people seemed to ease agitation and displays of negative behaviours. Care staff explained that these individuals remained *'so calm'* throughout the sessions, which provided reassurance for the rest of the sessions.

In both settings, larger care homes tended to have a greater number of staff responsible for the running and recruitment of residents to the activities. Despite having a greater number of residents overall, there were a similar number of residents attending the activities in the larger and smaller care homes. This suggests that there was a maximum group capacity for delivering activities to residents in both intergenerational and non-intergenerational settings. There was less of a push to get those who do not normally engage involved in activities in the larger care homes. Consequently, individuals in the larger care homes might be at greater risk of exclusion from certain activities, with activity co-ordinators picking and choosing residents who they

believe might be likely to be involved the most (especially given time constraints associated with visiting each residents room).

Facilitators often had limited choice over the space and materials used for activities. Most often activities were carried out in the common lounge of the care homes, where chairs were located around the edge of the room. One of the care homes found having the room set up in this way hindered interaction in the first session creating a physical division between the groups.

> The first session there was a clear sort of visual line down the middle of the room where the residents were sat one side and the children all went into one corner, I had to really work to try and get them to integrate at the start. To prevent this from happening in the second session which was the sort of sport session we moved the chairs into more of a circle, then the more sessions we had the less of a problem it came and it was more of a natural thing for them to walk in and go straight to the residents.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 152)

Having moved the chairs around, participants were better able to interact, creating a closer contact environment where participants could see and hear each other better encouraging greater interaction. In relation to transport resources that were used, most of the schools were within walking distance of the care settings. One school that was located at a distance from the care home opted to get the children to walk rather than use transport. Some of the children mentioned that they felt the walk was long when asked that they disliked about the activity programme, "We had to walk really far to get there my legs were tired" (Younger person, Intergenerational activity CH, participant 44). This is a factor that could potentially affect future participation of children in the activities. Transport options should be considered prior to implementing intergenerational activities. For instance, another school also located at a distance from the care home arranged their own transport to the setting. The school did not have their own minibus so they sought donations from local companies in order to cover the costs of a bus to and from the care home.

> Obviously the biggest potential barriers for us is the fact that the nursing home is too far for the children to walk. So, we've had to book a bus, and obviously busses cost money. And, it could have been a barrier in the fact that for each programme, I think it's about £160 for the bus. You know, lots of schools haven't got that. We've got it

because the head teacher realises how important it is, but also I've gone out looking for funding. And, because it's a community programme, the monies come flowing in, basically.

(Facilitator, Intergenerational activity CH, participant 70)

7.1.7. Fidelity

The initial intention for recruitment and numbers of younger people that were going to be involved changed for one of the intergenerational activity programmes. For example, one school was originally planned to take a whole class of twenty younger people to the care home. However. after speaking to the care home, facilitators agreed this might be too many children to have at once. To resolve this, ten names were randomly selected by the teacher. In contrast to the notion that intergenerational activities would have a greater positive effect on some children than others, this approach took into account the outcomes for older people and how they would benefit more from fewer more intimate interactions.

Many of the interviews with care staff and the self-reported facilitators handbook notes indicated that many of the sessions were run as intended and that there was very little they would have changed. Care staff were asked to report on how satisfied they were with how the activities have gone, overall 94% were either very satisfied (63%) or satisfied (31%) in the intergenerational setting, with just 6% saying they were neither satisfied nor dissatisfied. In the non-intergenerational setting 83% were either very satisfied (41.5%) or satisfied (41.5%) with how they had gone, and 16% saying they were neither satisfied nor dissatisfied. Staff saw the benefit of creating a care setting where there are activities and opportunities to interact with people of different age groups such as younger people, with over 80% of care staff in both settings indicating they would prefer a mix of generations within care homes, should they or a loved one need care services.

Overall 80% of care staff in the intergenerational settings indicated that activities had been delivered as intended, The majority of the facilitators in the intergenerational settings suggested that the activities had gone smoothly; and in some instances, '*much better than expected'*. However, many were also conscious of the fact that life gets in the way, and some of the activities did not always go as planned. In the intergenerational activity issues of miscommunication or lack of communication between the teachers and activity co-

coordinators was apparent on occasions. This is demonstrated in the following extract from one of the care home managers:

> No absolutely nothing at all, I can't fault it, It's been amazing. You can tell we are all really buzzing about it. It's been fabulous.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 35)

> There is nothing we can fault it with, you know some people are risk averse and say no no no, because you never truly know how the children and residents may react but they just got on with it. It's just flowed, which is lovely sometimes you just need to be on the ground level and get on with it rather than worrying about what could go wrong.
>
> (Care home manager, Intergenerational activity CH, participant 60)

Some intergenerational activity programmes did suggest they faced challenges. For example, one care staff stated

> I just think there could have been more room, it was a bit cramped at times. More came than I was expecting, and we haven't got the space really, to spread them out. They could have come in here, and there.
>
> (Care staff, Intergenerational activity CH, participant 76)

This quote illustrates that the issue of physical space could have been overcome had communication between facilitators been enhanced, as more younger people attended than the care home had expected. While space needed to be considered in terms of capacity and number of participants, the key thing highlighted in the intergenerational setting was the need for effective communication between the facilitators to improve the quality of the delivery of the programme. If communication had been better, care home staff would have been able plan more effectively and utilise different spaces within the care homes. No issues of space were highlighted in the non-intergenerational settings. Staff appreciated that activities might not always go to plan and that adaptability was needed to be response to unforeseeable situations. Lack of flexibility influenced the delivery of activities in the non-intergenerational settings too, as one activity co-ordinator explained

> If it doesn't work we'll think on our toes and do something else, because we arrange group activities, I arranged the cheese and wine a couple of weeks back and the

> residents were like, 'no, what are we here for?', and I was like, 'right okay we'll do something else', and it turned into a sing-song.
>
> (Care home activities co-ordinator, Non-Intergenerational activity CH, participant 133)

This quote highlights the a lack of communication between the residents and the care staff delivering the activities. In addition to this, in one intergenerational activity younger people sometimes found it difficult to strike the right balance between helping and guiding residents with the task in hand, and completing it themselves. One activity co-ordinator provided an example of this:

> With the iPads, I didn't know what training children had had because that was a separate project where they are trained before coming in. So they were actually doing a lot for the residents instead of doing it along with the resident and it being resident led. I was trying to sort out, encourage the students to say or ask the residents what they wanted to get from the session, and get them to start from the beginning so they know how to turn the computer on. They know the basics rather than just doing it for them. So with that with that respect I thought they might of done things a little differently but that was out of my control.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 80)

Although the facilitator was trying to promote and encourage intergenerational interaction by guiding younger participants, this example highlighted a lack of shared planning and disconnection between the digital IT training programme for younger participants and the needs of the older adults. In this instance it was because the children received training provided by a third sector organisation, who then passed the baton over to the teacher and the activity co-ordinator. This example also highlighted instances in which younger people 'outpaced' the older adults, exacerbating the generational difference in technological abilities.

> The teachers were encouraging them to work in pairs, or groups [with the older residents], which you could see, made them feel a bit more comfortable. And then, [care home] staff would try and help and be like, 'what was that again?', or, 'can you show me this little thing?.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 57)

This quote reiterates that perhaps the younger individuals were not fully considering the capacity of the residents to follow the activity, with the need for input from the facilitators to make the resident feel more comfortable. The facilitators would have benefited from a more detailed and thorough hand over concerning what training the children had already received, as this initially impacted negatively on the delivery of the programme. This issue of communication was also seen in another intergenerational activity programme where a lack of communication lead to the physical space becoming an issue:

> There was one time that the residents wanted to stay in the lounge because it was a bit chilly… they'd asked for us to be in the dining room because the kids had to walk around and do different things, and obviously in the lounge, there wasn't enough room… we always say when they first come in, 'right, is there anywhere that you'd like the residents to be?', and in fairness they normally say, 'wherever they're comfortable'. If they said to us, 'no, we need space', then we could have done a bit more planning for them, then. I think it's just general communication.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 122)

7.1.8. Flexibility and adaptability

Fidelity was impacted by the ability of the care home to be flexible. In the semi structured interviews, care staff in both settings spoke of the need to be flexible and responsive to the group's needs. It was apparent that if care homes are unable to be flexible and shift routines then intergenerational activities wouldn't be able to take place. The details and situations that required the care home to take an adaptable and flexible approach are described in the following section.

Both settings varied in terms of the timing of delivery, with activities carried out in both the morning and afternoon. Some care homes found that afternoons were best for care staff as it gives them more time to get residents bathed and dressed. However, some found residents were more alert and ready in engage in activities in the morning, as naps post lunch were common. There were differing points of views from activity co-ordinators as to when the best time for activities for the residents was. Variation between residents' preferences was highlighted by one of the activities co-ordinators. For example, one activity co-ordinator commented 'in the

mornings, they've just woken up, they've just had their breakfast, they don't like to do a lot of things, so that's when we normally have our tea and morning chat sessions' (Care home activities co-ordinator, Intergenerational activity CH, participant 152). Similarly another activity co-ordinator in the non-intergenerational setting commented:

> Morning activities I would say benefits quite a lot of the residents, it sets them up for the day, but then you get some of your residents then who like a lie in in the morning and would rather do the afternoons.
>
> (Care home activities co-ordinator, Non -Intergenerational CH, participant 140)

Facilitators raised practical issues in relation to the timing of the sessions, and the need to shift or adapt care home routines. In the intergenerational setting organising a start time which suited all stakeholders was negotiated between the care home and the school. The majority of the sessions were run just after lunch, between one thirty and two o'clock in the afternoon, with just two started at ten and ten thirty in the morning.

Lunch was a structured routine in all care homes, which the activities were predominantly negotiated around. In intergenerational settings, the main shift to routine was seen around lunch time, with many having to re-negotiate the serving of lunch with the kitchen staff. Three of the care homes explained that it worked out much easier for the children and older adults to have lunch together and to extend the amount of time the participants spent together "The only thing, we took lunch and things, earlier to involve the children" (Care home activities co-ordinator, Intergenerational activity CH, participant 21). Another commented:

> Yeah we had to get them dressed and fed in time. It was easier to have them have food down here because by the time the children came There was not enough time to transport everyone from different floors down to the room in time. So we would never of done it so they had dinner with us and everything and that's nice and itself.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 152)

The sessions that were run in the morning saw some care home staff struggling to get enough residents up, washed, dressed and fed in time for the arrival of the children. Especially when care staff are under pressure to carry out their day to day roles as it is, as one activity co-ordinator explained:

> We've got a lot of assisted feeds. And breakfast can take up to an hour and a half. And, knowing then that I need a specific number of residents for half past ten, on days that we're short-staffed, that's quite stressful. I don't want to let the school down, but I also don't want to add that pressure to the care staff either.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 35)

If care homes were inflexible in terms of the times they served lunch to the residents, or getting particular residents, up, washed, fed and dressed there would have been limited time in which the younger people could have made it to the care homes. Some of the afternoon sessions were rushed to get the younger people back in time for the end of the school day. There was clearly a balance between the number of residents attending, and the pressure put on staff to get the older adults to the activities in time, especially when sessions were run in the morning. There seemed to be more pressure in relation to achieving certain numbers of attendees in the intergenerational activities compared to non-intergenerational activities. The following quote highlights this, and the need to be flexible with the activities in general.

> I'll always be really flexible, if you think, 'right today I'm going to do mince pies', you might only get two people that might want to join you, or you might get 10 people that want to join you, sometimes you can spend ages prepping it all and no-one wants to sit there and do it. it's our job to motivate them and say, 'come on, come and just watch', and then obviously once they come and just watch, sometimes they'll join in and you just give them a little job each to do.
>
> (Care home activities co-ordinator, Non-intergenerational CH, participant 100)

Although all the activities were pre-planned in the start of the intergenerational activity programmes, many reported that the sessions were adapted as they went along to promote as much interaction between the younger and older adults as possible. For example, one care home manager explained, "sort of adapted it as I went along depending on how each session went I changed it slightly so they became less structured as the time went on it turned out they were mainly themes rather than specific activities" (Care home activities co-ordinator, Intergenerational activity CH, participant 56).

Another activities co-ordinators commented, “I think you just need to start it and it’s like a working motion as it progresses you find that somethings work and somethings don’t it’s about being flexible and responsive” (Care home activities co-ordinator, Intergenerational activity CH, participant 21). Again, another activity co-ordinator commented “we had a session planned with the iPads but there had been an incident at the care home so we ended up joining in with a Zumba class with many of the residents” (Care home activities co-ordinator, Intergenerational activity CH, participant 152).

These comments highlighted an emergent and flexible planning approach utilised by the facilitators, adapting to the context in which they were running the programmes, rather than utilising a strict planning framework. Despite a need to plan programmes, these quotes highlight the need to recognise that life is constantly changing, and especially so within the care context. Recognising this and drawing on developing a partnership approach, communicating and building relationships between the facilitators can play an important part in the quality of intergenerational programmes. The sessions in the non-intergenerational settings were also planned but were less structured than the initial planning that went into the intergenerational activities.

After the initial intergenerational sessions, facilitators in the intergenerational settings appeared to find a balance between structure and allowing for more informal, organic interaction of activities to come about. One activity facilitator explained how structured activities turned more into themes of the sessions as each week progressed. In both settings staff recognised that participants needs, abilities and interests were different. Adapting to participants responses abilities and helped support meaningful engagement and thus the quality of implementation. Adapting the content of the sessions to meet the participants needs was also reflected in the non-intergenerational settings:

> That everyone’s different, that everyone’s needs are different. Some things you can do together, even if it’s just painting a picture, but other things then you can’t, so it’s different abilities, you’ve got all the people with dementia and it’s different types of dementia
>
> (Care home activities co-ordinator, Non-Intergenerational activity CH, participant 100)

Another one commented:

> It very much depends on the day, on how people are feeling, so for example you could do an activity which you have spent weeks planning and you've put as much effort and really excited, and think, 'they're going to love it', and you do it and no-one enjoys it, everyone thinks it's awful and they want to go back and watch the TV,
>
> (Care home activities co-ordinator, Non-Intergenerational activity CH, participant 2)

In some instances residents who had limited attention and did not want to be at the sessions for the full length of time. This was recognised by care staff and they were on hand to take them back to their rooms.

> We do have a few here that don't have the time or patience so they did sometimes wander off, but even if they get 10 minutes from it it's still beneficial. They don't have to stay the whole hour if they didn't want to and if they want to wonder and come back that was absolutely fine. We still sore it is beneficial to them because most of the time they want to engage at all.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 21)

In some situations, care homes were unable to adapt sessions to suits the needs of all the older adults, specifically those with more server dementia displaying challenging behaviours.. As mentioned in the previous section, some care staff felt that the best way to adapt activity sessions was to run separate sessions for older adults with dementia and those without dementia. It could be argued that what needed to be adapted is the approach to understanding what certain displayed behaviours mean and delve deeper to the root cause of such behaviours.

7.1.9. Care workers capacity and perception of their role

Findings suggest that staff capacity and perception of their roles was also related to fidelity and quality of the implementation. Whilst care staff in both settings wanted to spend as much time with each older adult as possible, they spoke of being '*fully staffed, but understaffed*' as a limiting factor to their involvement in activities and the feasibility of spending one-to-one time with residents and delivering relationship centred care. Lack of resources in terms of staff, time and funding was considered an unavoidable reality that stands out as a potential threat to any future interventions. Care is the priority and with the expectation of the activity co-ordinator,

care staff viewed care and activities as independent of each other, as opposed to activities being part of their care plan. One activity coordinator noted "yeah I don't think they get that involved to be honest; they've got their job, we've got our jobs and they don't always appreciate how hard you work" (Care home activities co-ordinator, Non-Intergenerational activity CH, participant 61). Furthermore, another activity co-ordinator in an non-intergenerational setting commented

> I think one thing I would change is maybe have a bit more support from care staff; sometimes they'll just bring the residents to the group, leave them there and then they'll come and pick them up, but it would be nice for more care staff to stay and participate as well.
>
> (Care home activities co-ordinator, Non-Intergenerational activity CH 100)

This often sparked feelings of frustration amongst activity co-ordinators about the lack of recognition they received in relation to the running programmes.

> They don't get involved. We are babysitting company they don't see it as anything else. We go to the floor and they say take them take them all. I don't think they realise the impact … activity coordinators do have on the residents. It's not just the children coming, it's concept is everything, small little things. Since I made afternoon tea for one of the residents the other day and it made a really happy, but they don't see that. Even if it's just a one-to-one chat sometimes it makes the world to them. but it goes over their heads.
>
> (Care staff activities co-ordinator, Intergenerational activities CH, participant 121)

There was a difference in buy in from managers and support from other staff in relation to the activities in intergenerational setting compared to the non-intergenerational settings. With many of the care staff expressing their joy when they were on shift and knew the younger people were coming to the care home, as one care staff member explained "well I absolutely love being here on a Wednesday when they are here, because the atmosphere is amazing. People just seem to be happier all round, residents, staff, children" (Care staff, Intergenerational Activity CH, participant 118).

There seemed to more appeal and recognition of the potential benefits accrued by younger people coming in to a care home. As a result there were more resources and help from others

when planning and delivering the intergenerational activities compared to the more traditional activities. For example, these quotes demonstrate staff buy in with the intergenerational activities “everybody just wanted to get involved and see what was going on. Sometimes other members of staff would just come and watch” (Care home manger, Intergenerational Activity CH, participant 60).

In one of the intergenerational care homes one activity co-ordinator explained a slight shift in the way in which activities were viewed and their perceived value by other staff. One activity co-ordinator discussed the challenge of obtaining staff buy-in by stating:

> Over the last, I would say, two or three months, we’re sort of changing the way they see activities. Especially with the backing from the management. And activities are not just our job, it’s everybody’s job. So yeah, some people are starting to change the way they think of activities but some are stuck in their ways, they often say it’s not our job, we haven’t got time.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 56)

Facilitators who received additional support from care staff found it very beneficial and it affected the quality of the activity programme implementation. In other situations teachers received support from care staff. For instance, one teacher highlighted the need for support when some residents needed the toilet, or needed be be moved around in wheel chairs, while others who changed their minds about participating needed to be assisted to return o their rooms.

> Had the staff not been there, then it might have been a bit trickier for just me, sort of, going round all the tables. But, because there was so many of them with the residents that they knew who might need support or encouragement. In terms of just, making sure that the residents were comfortable and there was the odd one who, you know, actually they said they wanted to do it, and then didn’t want to do it. Or, they’d just get up and wander around, or they wanted the toilet, and things like that. With a lot of them, they’re in wheelchairs and things. So yeah, without the staff, it wouldn’t have been possible.
>
> (Facilitator, Intergenerational activity CH, participant 163)

Similarly, another activity co-ordinator reiterated the need for positive support from the care staff, as highlighted in the following quote “yeah, the staff were good. Two members of staff,

the same ones all the time, and then whoever was here would pop in as well" (Care home activities co-ordinator, Intergenerational activity CH, participant 35). Supporting staff also expressed gratification when getting involved in activities in both settings. One activity co-ordinator described a situation where one extra care staff was needed as they had so many people wanting to be involved in bingo. There was a sense of surprise at the amount of enjoyment she gained from being part of the activity. This highlights the potential benefit of greater care staff engagement with activities, regardless of role:

> They don't realise, one of the girls came down and helped us with the bingo because we had some many ladies and gentleman in, and she said 'oh you know what I really enjoyed it' because she was able to spend time and speak to people more. I mean in the ideal world it would be lovely if you could come in and it be one to three. But if you had one to three, you could take everyone to activities, you could concentrate on them three but it isn't going to happen, the money isn't there, let's be honest.
>
> *(*Care home activities co-ordinator, Non-Intergenerational activity CH, participant 118*)*

This activity co-ordinator highlighted issues concerning the ratio of staff to residents. She noted that a lack of resources was to blame for the lack of engagement from care staff. Involvement in activities was dependent on the staff levels at that particular time, for example a activity co-ordinator highlighted "when we have got enough staff in, and they are encouraging them to be involved in activities, it's amazing" (Care home activities co-ordinator, Intergenerational activity CH, participant 2). It was apparent that intergenerational activities drew more care staff in to watch and engage with the older adults and younger people, compared to the non-intergenerational programme activities. The intergenerational concept also gained attention of other younger educational and care settings in the area as one care home staff explained.

> Some staff did however show more of an interest, and there was a staff member who has children in another local school who have now got in contact with us someone to do something like this again, but with younger children so that's great… I feel like we've got the ball rolling. There was two teachers here with me as well when the children were here, but if I ever did need more staff I do get them in.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 151)

Although the intergenerational activities drew in more care staff than in the non-intergenerational activities activity coordinators were still frustrated about the lack of value attributed to their work. This was apparent in both settings, for example one activity co-ordinator commented "my main fight would be the carers, because they're so task orientated in their own job, they don't see that activities is an essential part of a resident living here" (Care home activities co-ordinator, Intergenerational activity CH). Similarly, a care home manger in the non-intergenerational setting came across similar challenges with care staff time and lack of recognition for the value activities bring:

> Well to be honest with you, because they're so busy, they haven't got the time to interact. There are so many things coming in new every time but I wish sometimes I wish they were more eager to get people to the activities. If we were to get 30/40 people ourselves, well it would take us all day. I just wish we had that push more.
>
> (Care home manager, Non-Intergenerational Activity CH, 130)

An activity co-ordinator in the non-intergenerational setting highlighted how much work they took home with them and that this was often no recognised by the other care staff:

> We take stuff home and work until 11/12 at night. We take food home and make food at home. we go shopping in our own time because we just don't have time in the day. It's not an easy job. People think it is, but I can tell you now it's not, it's far from it.
>
> (Care home activities co-ordinator, Non-Intergenerational activity CH 2)

Whilst the size and capacity of the care home has been shown to impact upon the quality of care, the size of the care home and its capacity of the staff was bought up by one of the care home managers in relation to the fidelity of the activities. In the non-intergenerational settings, the influence of the size and capacity of the care home was more apparent. Some of the larger organisations demonstrated greater capacity to implement the activities, with more than one activity co-ordinator and an activities and lifestyles team instead. For example "I'm heavily involved, I lead the team, the lifestyles team, I mostly do all the planning, the arranging, the booking, and then between myself and my team we facilitate it" (Care home activities co-ordinator, Non-Intergenerational Activity CH, 163)

Care homes with a dedicated lifestyles team seemed to be less stretched and more resourced to implement activities. This was a factor in determining the quality of the activities delivered in both settings. This difference between size and staff capacity to run activities was more apparent in the non-intergenerational settings. For example, in a smaller care home the lone activity co-ordinator noted that other care staff did not take any responsibility for implementing meaningful activities. For example, she noted that magazines were left for the residents to read but they were not handed out:

> I think activities is everybody's business, but what annoys me is when we've left stuff out for them for the weekend and they're still on the table when we come back and you know they haven't handed them out, basic things like magazines
>
> (Care home activities co-ordinator, Non-Intergenerational activity CH, participant 163)

Another lone activity co-ordinators added, "it's hard sometimes when you're trying to take the class and help the residents" (Care home activities co-ordinator, Non-Intergenerational activity CH, participant 118)

In the intergenerational settings, smaller care homes seemed to be less affected by this primarily because the nature of intergenerational activities meant there were additional members of staff from the schools who helped facilitate the sessions. Furthermore, the presence of the children provided more one to one engagement opportunities, attending to residents social needs. The enthusiasm from care staff for the intergenerational activities was evident. This often seemed to act as a buffer to the widespread issues surrounding staffing capacity, despite still being a factor in the intergenerational settings. One facilitator explained "it is just so, I can't even really put into words, why we do it. I can't. But, when we do do it, it's so powerful, we won't be stopping, 100%" (Facilitator, Intergenerational activity CH, participant 70)

While there may be a perception that intergenerational activities will increase workload of the activity co-ordinators role, many in the intergenerational settings spoke of their surprise at how much they were able to step back from their co-ordinating roles and watch:

> Quite a lot of the time I was surprised at how I was able to stand back and not have to be involved and be as hands-on as I normally am with activities to be honest. The

children took the lead really, there was never a point where I felt like I needed to step in and it was just all very natural.

(Care home activities co-ordinator, Intergenerational activity CH, participant 163)

However, it should be noted that many of these care homes would not have opted to take on an intergenerational programme as extra work for facilitators if they viewed staff capacity as a barrier to the delivery of the activities. This, however, was in contrast to some of the non-intergenerational settings where activity co-ordinators described being overwhelmed and overstretched:

Full on because I'm the only one who does the activities. The thing is I said with the girls, they're busy but even if it's just sitting with someone and helping them at the bingo, or to help them do colouring and things like that, but obviously the budgets and things like that and the staff, they're always busy so it just seems to be, sometimes it's quite hard though on your own.

(Care home activities co-ordinator, Non-Intergenerational activity CH, participant 163)

7.2. Mechanisms of impact

This section draws out themes from semi structured interviews, facilitator feedback notes and intervention feedback questionnaires, relating to the processes that may have impact on the outcomes highlighted in the summative evaluation, and factors associated to the processes that affect might impact certain outcomes associated with the running of intergenerational activity programmes in care homes.

7.2.1. Quality of interactions and the development of relationships

Whilst it was anticipated that relationships might have formed amongst participants having reviewed the extant literature, the extent, quality and speed at which such relationships and friendships were formed were unexpected. One activity co-ordinator explained 'It was just how quickly and how easily they were able to like, form these friendships with people they'd never met before, that were so much older than them, and the things that they had in common' (Care home activities co-ordinator, Intergenerational activity CH, participant 61). A facilitator also explained her surprise in how little they had to do to encourage the younger people to get

involved ‘The very first time I went down there, I wasn’t expecting the interaction. I was expecting to have to go round and really jiggy them up, and I didn’t. No, it literally just flowed’ (Facilitator, Intergenerational activity CH, participant 100)

The quote above denotes the sense of pleasant surprise at how receptive the younger participants were to engaging in conversation. In the non-intergenerational activities, the activity was the central focus. For example, many of the non-intergenerational activities programmes had external singers come into the home and sing to the residents in a large group. Whilst many enjoyed this activity, despite care staff trying to get residents to sing and dance, conversations and communication was limited, and often residents sat in silence for the duration of the activity. In comparison to this the activities in the intergenerational activity programmes often instigated conversations and interactions with little reference to the specific nature of the activities. Instead focus was on the value of each other’s company, with the opportunity to learn from each other being highly valued, for example one older adult commented ‘You can always learn from the children. There is always something that they will say, do. You live and learn from each other (Older adult, Intergenerational activity CH, participant 24). While younger people also found great value in conversing with the older adults ‘The residents were very helpful and provided some really good advice about exams, had a great insight into life and were really easy to speak to’ (Younger person, Intergenerational activity CH, participant 19)

The activities acted as the catalyst for conversation in intergenerational settings. Participants revealed things about themselves and commonalities between generations were established., that might not have been without a means to start communicating. One care home staff mentioned how they quickly found out things that they had in common, which sparked conversations and engagement between the participants:

> Like one of them was doing things about Australia with one of the residents because she had been to Australia and they were talking about holidays and things she enjoyed And they were just sharing their stories so it was really lovely to watch this natural engagement between them
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 52)

The planned activities were less relevant as time went on and relationships and friendships started to form. For example, using the iPad facilitated conversations about subjects of common interest, revealing things participants had common such as travel, playing the piano. As a result, the activity often took the back the foot and the relationships and interactions appeared to be a key driver of the intergenerational programmes. For example, one activity co-ordinator explained:

> The sessions started to be less about the iPad and more natural organic play and conversations started to occur. We still kept technology as our theme and the residents and children still used them but you could just see everyone chatting and laughing it really was lovely to see.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant)

Another activity co-ordinator described how fond one of the residents became of the boy involved in the activities:

> She absolutely adores one of the boys… Every week she was there going, 'oh I love him, I want to keep him. Can I pay you for him?', and I was saying, 'no, you can't keep [Name of younger person]
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 35)

For participants, the quality of the interactions with the younger participants was the source of enjoyment. Many of the participants shared stories that highlighted the quality of the relationships that had been formed, with the relationships described as '*amazing*'. The reference to the formation of special friendships was woven throughout the feedback provided by all participants, with staff, older adults and younger people referring to the participants as friends, for example one care staff explained "we've had little friendships form in the groups like [younger participant] and [older participant] their best friends they got to see each other every week" (Care home staff member, Intergenerational activity CH, participant 29)

> The boys class [older adult] as their friend now. I think that's the thing, the children have said the word 'friends', are we seeing our friends they would say. And that's significant. Because they are innocent little kids and that's genuinely how they see it. Its great we have that link now.
>
> (Care home manager, Intergenerational activity CH,152)

The quality of the relationships was reflected in the continuation of these friendships and ongoing thoughtfulness of younger participants after the sessions had come to an end. For example, some younger people make gifts outside of the sessions to give to the residents in the care home as demonstrated by the following extract taken from an interview with one of residents who spoke of a relationship she had struck up with one of the children during the course of the activity programme:

> There was a lovely the little girl who painted me an ornament. she painted it in her own time. The colours and everything are lovely. We paired up a few times, she took a shine to me and for no reason at all… But you know and things like that, when they give you anything like that it's given with love and real thoughtfulness… it's like well she cares about me, when perhaps others don't.
>
> (Older adult participant, Intergenerational activity CH, participant 33)

This exchange of gifts and the new possession of objects made by participants, highlighted an emergence of symbolic interactions that were present in many of the intergenerational activity programmes. In line with symbolic interactionism these were processes of meaning-modifying interactions between participants, including their self-interaction. The younger girls action impacted on the resident in terms of how other people 'cared' and perceived her as a person. Developing and altering the meanings associate to the activities and the little girl, strengthening that relationship and the communication between them. This was reflected in the behaviours of younger participants who were drawn to particular residents, with many examples of the younger people instantly pairing up with the same resident each week. For example one care home activity co-ordinator explained "the children latched straight to the same one, you like [younger person] with [older adult] and [younger person] with [older adult], they knew which resident they would go to then" (Care home activities co-ordinator, Intergenerational activity CH, participant 83). Younger participants often decided to go to the resident they had been paired up with from the beginning out of choice. However, care staff reiterated the importance of having smaller groups from the same unit, and the influence it had on the formation and development of the relationships and friendships.

> I think it is key to have it in the same unit in the home and the same children. Definitely. Definitely do that, you can attempt then to help build meaningful relationships, well the children then are building the relationships.
>
> (Care home manager, Intergenerational activity CH, participant 103)

In the intergenerational settings many staff spoke of initial concerns about how participants, particularly those with dementia, would interact. For example, facilitators thought they would have to try and encourage conversations and engagement. However, consistently across all care homes, staff expressed surprise at how quickly and naturally participants engaged with each other.

> I think we have all learnt very quickly that it just flowed and gone really smoothly and you can get caught up with risks, but it's just been brilliant.
>
> (Care home manager, Intergenerational activity CH, participant 60)

Interaction between participants was at the heart of the intergenerational activities. It was apparent that having the opportunity to communicate with the children enabled greater social interaction and engagement in the sessions. Great value was gained from talking and being listened to, and it appeared to be the quality of the interactions between the younger people and older adults that older adults in particular sought great enjoyment from. Strategies implemented by the staff facilitators helped to promote such interaction such as the pairing up of the younger children with residents. Programmes that had one to one approaches or smaller groups found that it helped facilitate the development of rapport between the older and younger participants and enabled greater engagement. For example, one care home manager explained:

> I suggested the following week that we separated them into four separate tables. So we did a table doing cake decorating, arts and craft table where they made name badges and a little bingo table where one of them called bingo and to help them mark their cards. Then each week we alternated them so they would move onto the next table….. in the ideal world we would love them to come in and just scatter everywhere but that wasn't very beneficial we need something a bit smaller and more organised so they could get something out of it.
>
> (Care home manager, Intergenerational activity CH, participant 152)

Another activity co-ordinator explained the benefit one to one interaction had on a specific resident:

> I think he enjoyed the one-to-one conversation with the children, so I think for him personally he got a lot from it and I think the more sessions you have the more people benefit from a building relationships with them and the companionship sharing their stories.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 48)

Some of the intergenerational programmes switched who the younger people were with each week, however there were numerous examples of where specific children were drawn to particular older adults and friendships had clearly been formed in the intergenerational setting:

> Like, even when the children were advised by the teacher to rotate, some of them were like, magnets to each other. They sort of like, would go back to the same resident, each session.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 86)

The non-intergenerational activity programmes also found it beneficial to have smaller more intimate group activities and one to ones. One activity co-ordinator explained how this became apparent the more activities she ran:

> I used to think, 'the more the better', get everyone in here to do flower arranging or baking, but now I've realised sometimes you're better off with a smaller group and do more…because that way then you can really concentrate on individuals and help them the way they need to be, so they get more out of the activity rather than a big group
>
> (Care home activities co-ordinator, Non-Intergenerational activity CH, participant 102)

It was a fine balance between quality and quantity of the delivery of activities. Many care homes would love to provide specific activities to meet every individual's needs, yet it was apparent that time and resources were the key barriers to enabling this. An activity co-ordinator in the non-intergenerational settings expressed that although the policies were in place and targets were set, the funding and resources provided were insufficient to achieve the levels of engagement to fulfil the policy recommendations:

> I think that's across the board. They want you to do certain things but they don't give you the equipment to do it. We need this, we need that, we need photos, me and the other activities co-ordinator are in the office waiting for the manager to finish with her computer. It's no good is it ?
>
> (Care home activities co-ordinator, Non-Intergenerational activity CH, participant 02)

Combining the resources of the school and care home was one way in which physical and social resources were better utilised to enhance the experiences of activities for all stakeholders. Intergenerational activities enhanced the direct one to one interaction for the residents on a relatively small budget. One activity co-ordinator noted that intergenerational activities did not use the care homes budget, yet provided the social stimulation and engagement the residents needed and thrived on:

> It's a free activity as well. Like, I don't have to use my budget. It's community. You know, they come in for free, and I don't understand why other care homes are not doing it.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 21)

In one of the care homes the difference between carrying out an activity with and without the children present was described by an activity co-ordinator. He noted that whilst the activities were run exactly the same in both cases, it was the interaction that made them much more meaningful to everyone involved.

> Some of the activities we have done previously with the residents but without the children and they it went in a similar fashion. But I think the main difference was the way they interacted with the people around them as opposed to it just being between the residents. The social interaction was enhanced which I think benefits everyone and makes the activities more enjoyable as a result.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 86)

In the non-intergenerational activities, whilst interaction was still evident the depth of interaction and engagement seemed to be less. In many of the non-intergenerational settings it was often down to just the activity co-ordinator to run the activity themselves. However, the

pairing technique was also used in the non-intergenerational setting to enhance engagement and interaction amongst the different capabilities of the residents as one activity co-ordinator explained:

> Yeah we open group activities up to everybody in the home depending on who comes, we try and tailor it to suit different peoples' needs, and we try to pair people up then, so the likes of [Resident} who's quite willing to sit with somebody with a diagnosis of dementia, and she'll help them as well.
>
> (Care home activities co-ordinator, Non-Intergenerational activity CH, participant 118)

Another activity co-ordinator noted that the way in which the older adults interacted with the children was completely different as to how they interacted with the staff at the care home, enabling different forms of communication.

> I see the residents on a daily basis of course and you see them from a staff member perspective but the way they interacted with the children was the way in which we don't see here, it's just kind of completely innocent if you like, it's just a completely different way where they communicate differently.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 61)

The interaction they had with the children acted as a welcomed distraction for many of the older adults. Participants explained how the intergenerational activities engaged them for that hour. The main focus was the younger people, and residents did not think about anything else other than being in that moment with the children.

> It gave you something to talk about with the other residents and made you feel like somebody cared in a way, because they would always be so excited to see you and you just forgot about whatever might be irritating you that day.
>
> (Older adult, Intergenerational activity CH, 99)

7.2.2. Attitudes and understanding

The simple experience and understanding of care homes gained by the younger people involved in the activity programmes is something that was demonstrated in the responses to open ended

questions by younger people. Out of the 96 younger people included in this research only 17% had visited a care home before. Symbols of meaning drawn upon by younger people in relation to older adults also changed throughout the course of the activity programme after repeated meaningful interactions. For example, at baseline on the CATE many of the younger people referred to symbols of physical appearance when describing older adults, these tended to be negative and stereotypical in nature, such as '*they have wrinkles'* and '*They can't walk properly'.* At the eight week data collection, many of the younger people used less stereotypical descriptions of older adults when asked the question on CATE '*what can you tell me about old people'* and 'what did you learn when being involved in the activities', for example responses included: 'Old people can be artists' (Younger person, Intergenerational Activity CH, participant 14), 'They are really nice and kind'(Younger person, Intergenerational Activity CH, participant 111), 'They're actually very clever'(Younger person, Intergenerational Activity CH, participant 71), 'They are much kinder than younger people' (Younger person, Intergenerational Activity CH, participant 110), and 'Not all old people are the same and I became more confident' (Younger person, Intergenerational Activity CH, participant 16).

Although, the CATE responses indicated positive changes in attitudes towards older people, and extract from the follow up interviews illustrate that amongst some of the younger, the more stereotypical image of older adults physical appearance remained. One of the care staff observed a young boy aged five involved in the activities with the older adults, and recalled the following story..

> He drew a picture of [Older adult] and it was funny because he said, she's got a stripy top on, so I have drawn the stripes on her top, and I have drawn the stripes on her head as well. So we [Care staff] said what do you mean, and he said you know these the lines, the wrinkles.
>
> (Care home activities co-ordinator, Intergenerational Activity CH, participant 57)

However, throughout the course of the intergenerational activity programmes younger people were provided with repeated opportunities to engage with older adults. These opportunities created open-minded environments to challenge and think critically about the social representations of older adults and their interactions and behaviours with them, for example one activity co-ordinator explained how the children's behaviours changed:

I mean the children gain a good understanding of care homes I think there is a stigma there and that the children can get past that, once they've come here and I definitely saw the difference between the first session and the last session and how they were approaching the residents and communicating with them.

They were more understanding of the needs of the residents especially those that were hard of hearing they knew them by the last session what each individual needs are and how they could adapt best to overcome them in order to communicate with them for example hearing eyesight etc.

(Care home activities co-ordinator, Intergenerational activity CH, participant 122)

Home)Younger people demonstrated an increased awareness and understanding of the needs of the older adults. The qualitative data supported the results revealed in the children attitudinal questionnaire, as demonstrated by the following quote from an activity co-ordinators perspective and the emotional it made them feel when witnessing such behaviour:

I think so, you can already see, they're only little kids….but you can see the natural elements coming out in the kids, for example [Younger participant] with [Older adult] , its intuitive, it's there, kind, caring understanding, it all came out. They wanted to be here… It was so sweet. It brings a tear to your eye it really does.

(Care home activities co-ordinator, Intergenerational activity CH, participant 48)

Certain behaviours demonstrated by the younger participants seemed to evoke a natural caring environment, the following quote further highlights the unforced nature of such behaviours by a little girl who helped a resident

This lady here, she was unwell she had a stroke in between, only a mild one, but [Name of younger participant} the little girl that was supporting or was with her, because the effects of the stroke meant that [resident] was dribbling a little bit, [Younger participant} was so natural she gave her a tissue and said here we are [resident] wipe your face , it was just so sweet, so sweet, it's been amazing!

(Care home manager, Intergenerational activity CH, participant 103)

Activities in both settings altered the way in which communities viewed or perceived the care homes. Often care staff reported that visiting external groups were often surprised at what life was like within a care home, especially if they had never visited a facility.

> They [local stroke club] come here when we have a fete, they do a stall… And a lot of ladies and gentleman that come in say to us, I would never imagine a care home being like this, It would never have even come into their head… Because they are coming into the care home and they are seeing that life is the same, more or less… it's not regimental, it's not a lock down unit. If you want to go out to the garden you go out to the garden. A lot of people have a false view of care homes, where it's all about bed baths and stuck up nurses, years and years ago.
>
> (Care home activities co-ordinator, Non-Intergenerational activity CH, participant 2)

Intergenerational activities also allowed care staff to gain a greater understanding of residents. The intergenerational interactions stimulated conversations about residents' past which care staff had not seen before. Care staff and managers noted that new information was added to their documentation and enabled them to tailor care around this new information:

> Definitely enhanced [care] because we know more about the person and the more we know the better in terms of the care we can deliver. Even down to things like our documentation now, that we will add life story work into that, I can't fault it.
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 118)

Similarly, in non-intergenerational setting, activities also helped staff reform attitudes towards residents.

> When I came here I was told that one of the residents, all he ever does is eat sweets and watches TV, but that's because he always declined. I've got him doing floor games, he was making a Father Christmas thing with me with the glue and the glitter, but saying that, some residents take more to some people than others.
>
> (Care home activities co-ordinator, Non-Intergenerational activity CH, participant 26)

Younger people demonstrated greater appreciation and respect for the older adults at the end of the intergenerational activities, with many being surprised at the advice they gave.

Secondary school age children found advice particularly helpful, with them providing advice around exams and working life, as highlighted in the following quote, 'We definitely need to engage with them more, be more friendly and open to their advice, they gave me some really good advice about my exams' (Younger person, Intergenerational activity CH, participant 66)

7.2.3. Symbols of meaning

Throughout the course of intergenerational activity programmes there was a common theme in relation to the creation of different objects and possessions. At the end of the intergenerational activity programmes younger people appeared to want to create lasting memories and offer something to the older adults with whom real connections had been made. In one of the care homes, younger people made cards for the older adults. our programme June, they actually went into the summer holidays, back into the nursing home. They took their child back in' (Facilitator, Intergenerational Activity CH, participant 100), and as a care home manager highlights:

> He [Younger participant] was talking to [Activity co-ordinator], and he was so proud of bringing these little chocolates and flowers in bless him, he said my mother went out past midnight to get these, so it's obviously really important to him…But they [the parents] must be so proud of their children, I know I would be, 100%.
>
> (Care home manager, Intergenerational Activity CH, participant 130)

Figure *12* shows a handful of the cards created by a younger participants for an older adult they had been paired up with, with personal messages and pictures. This unintended, but significant creative data, revealed how much the younger people valued the opportunity to form new friendships with older people.

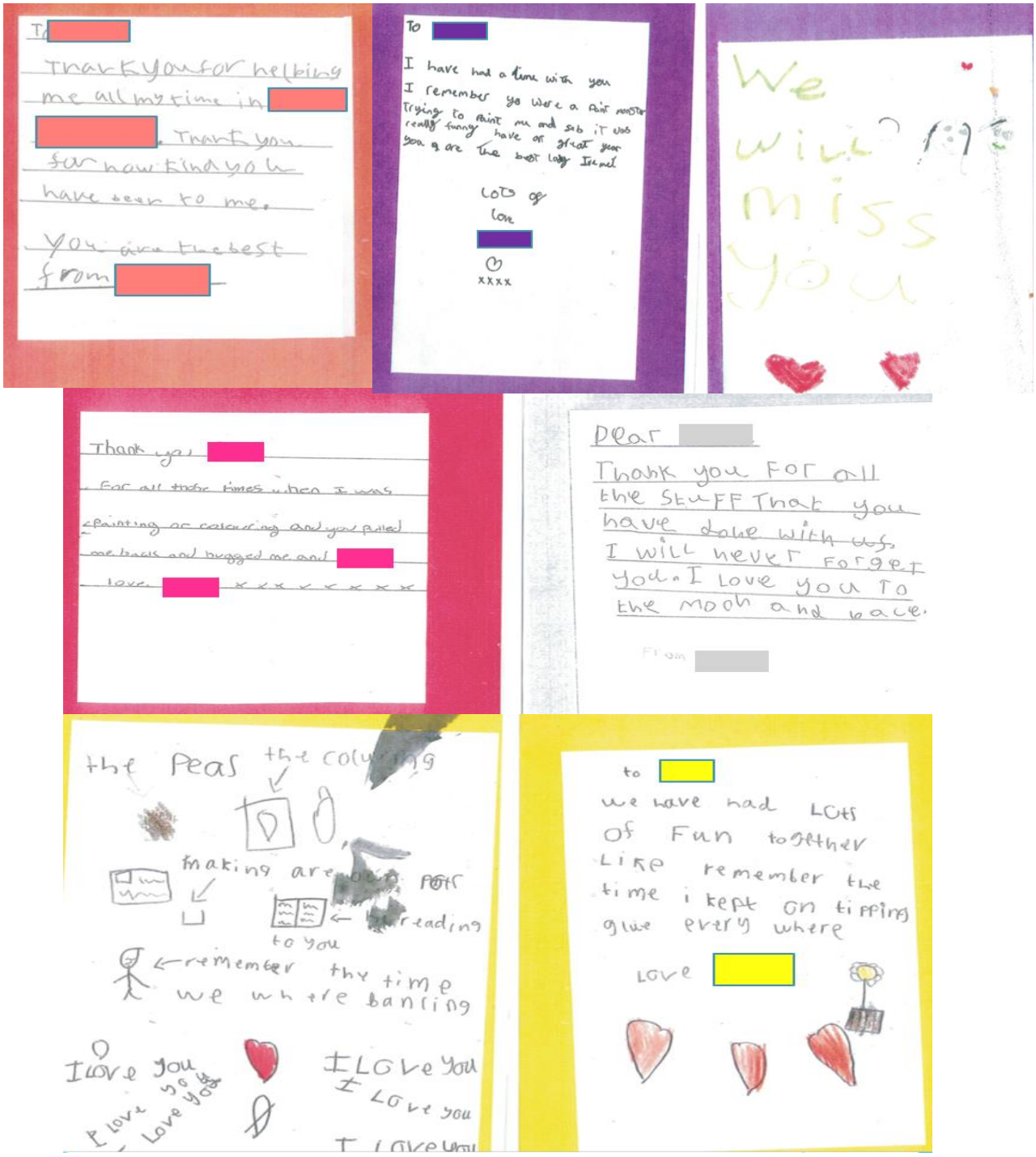
The quality of the relationships formed was reiterated by the giving and receiving of gifts that extended beyond the cessation of the intergenerational activity programmes. Benefits extended beyond the sessions, with participants demonstrating affective behaviours towards the residents in their own time. For example, one boy who, asked his mother to go ou*t 'past midnight'* to get gifts to give to the resident. This suggest that conversations extended into participants' homes, enabling friends and family to understand the significance of the impact the activities had on

the children. As the following quotes demonstrate: ‘I know one of our families, we finished our programme June, they actually went into the summer holidays, back into the nursing home. They took their child back in’ (Facilitator, Intergenerational Activity CH, participant 100), and as a care home manager highlights:

> He [Younger participant] was talking to [Activity co-ordinator], and he was so proud of bringing these little chocolates and flowers in bless him, he said my mother went out past midnight to get these, so it’s obviously really important to him…But they [the parents] must be so proud of their children, I know I would be, 100%.
>
> (Care home manager, Intergenerational Activity CH, participant 130)

Figure 12

*YP handmade cards given to OA in IA*P



The narratives highlight the sense of pride, and the enjoyment that the younger person must have relayed to his mother. This sharing of experiences with families may potentially act as a trigger for creating more inclusivity with care homes, whereby visiting becomes a part of the everyday lives of people. Moreover, a sense of community may be enhanced via the sharing of

gifts. In contrast this was less apparent in some of the intergenerational settings in which one resident described the care home as being closed off from community 'Most of us have a laugh, because you know, you're sat here, you're only in a closed community, you've got to get on as best you can. I think we all get on okay more or less' (Older adult, Non-Intergenerational Activity CH, participant 80).

A consequence of the creation and giving of artefacts meant that in many cases the residents' rooms in the intergenerational settings were dotted with memorabilia from the sessions. In many cases this acted as a daily reminder and evoked positive memories of the relationships with younger people that were developed during the intergenerational sessions. These also seemed to generate discussions between residents and care staff, as one activity co-ordinator highlighted 'When you go into their rooms 'Oh look, the picture that you made with the children'. It's definitely a hot topic of conversation with all the staff here and myself' (Care home activity co-ordinator, Intergenerational activity CH, participant 34).

After the end of the programme, the symbols of the activity seemed to prolong and sustain the positive outcomes demonstrated by the involvement in intergenerational activities. These extended beyond the care home setting and into the community with experiences of positive contact rippling through families and friends of those involved. For example, one care staff explained:

> I think it was the son of a mum there, while we were there…For her to turn around and say, 'so are these the little ones then, who have been making all of mum's special things in her bedroom?'. Because, whatever they make, they've got cards, they've got photo frames, they've got flowers, they've got a bit of everything, in their bedrooms.
>
> (Care home Manager, Intergenerational activity CH, participant 60)

Another also commented:

> Yeah, it's not just like, a one-off activity for them. They were obviously going home and discussing with their families and working with their families to like, you know, go to like, a pottery place, one of the little children went to and painted an ornament.
>
> (Care home activity co-ordinator, Intergenerational activity CH, 118)

One care home staff mentioned how they quickly found out things that they had in common, which sparked conversations and engagement between the participants:

> Like one of them was doing things about Australia with one of the residents because she had been to Australia and they were talking about holidays and things she enjoyed And they were just sharing their stories so it was really lovely to watch this natural engagement between them
>
> (Care home activities co-ordinator, Intergenerational activity CH, participant 21)

7.2.4. Significance of the activities

Compared to older adults in the non-intergenerational setting, intergenerational activities appeared to be more meaningful for those involved compared to non-intergenerational activities. One activity co-ordinators explained that it was hard to capture the true power of intergenerational activities, It is just so, I can't even really put into words, why we do it. I can't. But, when we do, do it, it's so powerful, we won't be stopping, 100%' (Facilitator, Intergenerational Activity CH, participant 70)

The activities with the younger people elicited story telling amongst the older adults involved. The recall of experiences was accompanied with a positive behaviour change. For example, one woman (whose narrative has been amended to de-identify) demonstrated enjoyment and laughter when telling the following story about the activities:

> We had to play this game and they had to think of words that matched with my name Maria: M - marvellous , A – amazing, R - ravishing, I - interesting and A – artistic. And I was laughing. We were doing drawings and oh my gosh some of them and they drew me and my god I looked like Dracula.
>
> (Older adult, Intergenerational Activity CH, participant 59)

This enthusiastic story telling when recalling experiences of the activities was absent in the non-intergenerational settings. For some older people the activities with younger people elicited fond memories of past employment. New information was added to the residents' notes and enabled the care homes to tailor care. This was illustrated by one of the care home managers:

> Massive outcome for the likes of [Resident] to have that. You know what her job was, and this will shock you, and I didn't know this… Her job was a main toy buyer [in a

> department store]. Children isn't it. So it's a massive outcome for her to be involved with those kids. Massive. We've now been able to add this to her notes.
>
> (Care home manager, Intergenerational activity CH, participant 152)

Both children and the older adults opened up about experiences they had, with some suggesting the children boosted their confidence, and that it was often the little things that resonated with the participants and facilitators the most. For example residents commented on other residents changes in body language and behaviour during the intergenerational activity.

> I have never seen him with such a smile on his face in the whole time I've been here. It was just small things Like that nothing major but just things you can't really capture or kind of grasp in terms of data when running these types of things it's just so nice to see.
>
> (Older adult, Intergenerational Activity CH,)

> For one in particular, her appearance changed because she can be quite down sometimes, but she was looking forward to the children, she remembered their names, she was interested in the children.
>
> (Older adult, Intergenerational Activity CH)

One resident also commented on how the children had affected his confidence, 'They've taught me be more confident and believe in myself more, they were quite motivational actually because they were all self-assured'(Older adult, Intergenerational Activity CH, participant 66). Activities in both settings provided enjoyment for older people. Activities that injected an element of fun into care environments acted as a welcome distraction from the complex health or care needs of residents ' Having fun, singing, bingo, that's just a laugh when the children are here, it's getting bigger and bigger each week. But yeah, just sense of fun I think, we like to interact, so interaction and fun and you forget about the other things' (Older adult, Intergenerational activity CH, participant 147).

This sense of fun was especially evident in the intergenerational activities. When younger people were asked to describe their experience of the intergenerational activity programme in three words, fun was one of the most consistently cited words. The word fun was counted 24 times compared to the next most counted word interesting with 14 counts. Other adjectives

such as happy, enjoyable and wonderful were also used to explain the experiences of the younger people involved in the activities (Figure 13).

Figure 13

Word cloud of words from younger people's descriptions of the IAP

This sense of enjoyment appeared to have a rippling affect throughout the care homes, as one care home manager explained ‘Honestly, it benefits us all, it’s gone right through the home you know, the positive vibe, it’s just lovely’ (Care home manager, Intergenerational activity CH, participant 152).

As demonstrated with the exchange of gifts and other objects between younger and older participants that sustained a positive effect beyond the duration of the intergenerational activity programmes, the significance of the activities also spread beyond the care home. Many family members and friends of the children relayed their positive thoughts and views about the programmes to the activity facilitators:

> A family member of one of the school children, let me know how pleased she was about the idea of the whole program and the whole concept of all of this partnership if you like, and was thrilled her child was part something like this.
>
> (Facilitator, Intergenerational activity CH, participant 35)

For older people, intergenerational activities were enjoyable and a rewarding experience as they were able to help and talk on a one-to-one basis when in the company of the younger people. Younger people also got pleasure from the activities which were also significant to them. This is demonstrated in the following quote from one of the activity co-ordinators:

> The kids loved it. One of the little girls when she was walking out said [Activity co-ordinators name] '*it is the best day I've ever had'* she said, '*I've been to Universal Studios and Walt Disney but this was even better than that it was the best day ever*'.
>
> (Care home activity Co-ordinator, Intergenerational CH, participant 57)

Overall, 94% of the younger people indicated that they had enjoyed the IAP and only 6% said they had not enjoyed. Similarly when asked if they would like to continue visiting the care home 84% said they would like to continue visiting the care home, 12% said they didn't know and only 4% said they would not like to continue being involved in the IAP. When older adults were asked if there was anything would change about the activity programme, one suggested that wanted the children to stay longer. This highlights the desire for more engagement, but there was also recognition of the difficulty in bringing the younger people out of school by one of the residents:

> It is only for an hour so it is really a brief thing but I would love for it to continue. I shouldn't imagine you'd be able to do more than an hour because these children are taken from school but you know just that hour it amazing, it brightens up my week but it just goes so fast.
>
> (Older adult, Intergenerational Activity CH, participant 93)

As well as the positive impact of activities for residents and younger people, care staff that were involved in the delivery and running of the activities in both settings expressed a sense of fulfilment and reward. This stemmed from the knowledge that they had made a positive impact on the residents' day. Activity co-ordinators were the ones that expressed the greatest sense of

job satisfaction, enhanced by the presence of the children as demonstrated by the following quote:

> I don't know how to explain it gives me a sense of achievement to get everyone involved to get them here it's nice I don't know it's just nice to see them all getting along together and you know sort of entertaining each other and enjoying each other's company. So yeah it makes me feel really happy and like I've achieved something meaningful at the end of the day. I can leave and go yes, I've done something good
>
> (Care home activity co-ordinator, Intergenerational Activity CH, participant 122)

Another activity co-ordinator got great pleasure in seeing the formation of relationships between the participants:

> Yeah, absolutely. It does impact me, because I feel like I'm so protective over them. I mean, I guess seeing those relationships form, is so rewarding. My end goal at the end of every day is, as long as I've made them happy today, and their day has been broken up with some sort of stimulation and something different, and something fun, then that's my job done. And, seeing the pure joy there, that's most rewarding.
>
> (Care home activity co-ordinator, Intergenerational Activity CH, participant 48)

Other activity co-ordinators felt rewarded by observing behaviours younger people exhibited when interacting with the older adults. They were particularly impressed that some younger people were able to develop a greater understanding of the older adults and learnt how to react and respond appropriately, as one care home activity co-ordinator explained:

> That gave me a great sense of satisfaction knowing that they have taken away something practical and learn something from this experience as well as form friendships and have that connection with the older adults.
>
> (Care home activity co-ordinator, Intergenerational Activity CH, participant 86)

This altruistic and caring behaviour also impacted on the activity co-ordinators emotionally:

> One of the children seen a resident about to come to the door and immediately went to assist her through the door without anyone asking her to. She's really kind and gentle because nobody asked her and she just went and she said 'are you alright' whilst holding

> the door and guiding the resident through, and that's an eight year old. They just melt your heart.
>
> (Care home activity co-ordinator, Intergenerational Activity CH, participant 21)

Observing the connections made between the participants impacted upon other care staff and managers. For example, one manager commented:

> They are amazing aren't they. [Older adult] had two little children with him, [Younger participant] and [Younger participant] I think. They gravitated to [Older adult], and he was holding the both of them, one on each side of him throughout most of the sessions. We are all really touched by it, it's been amazing.
>
> (Care home manager, Intergenerational Activity CH, participant 60)

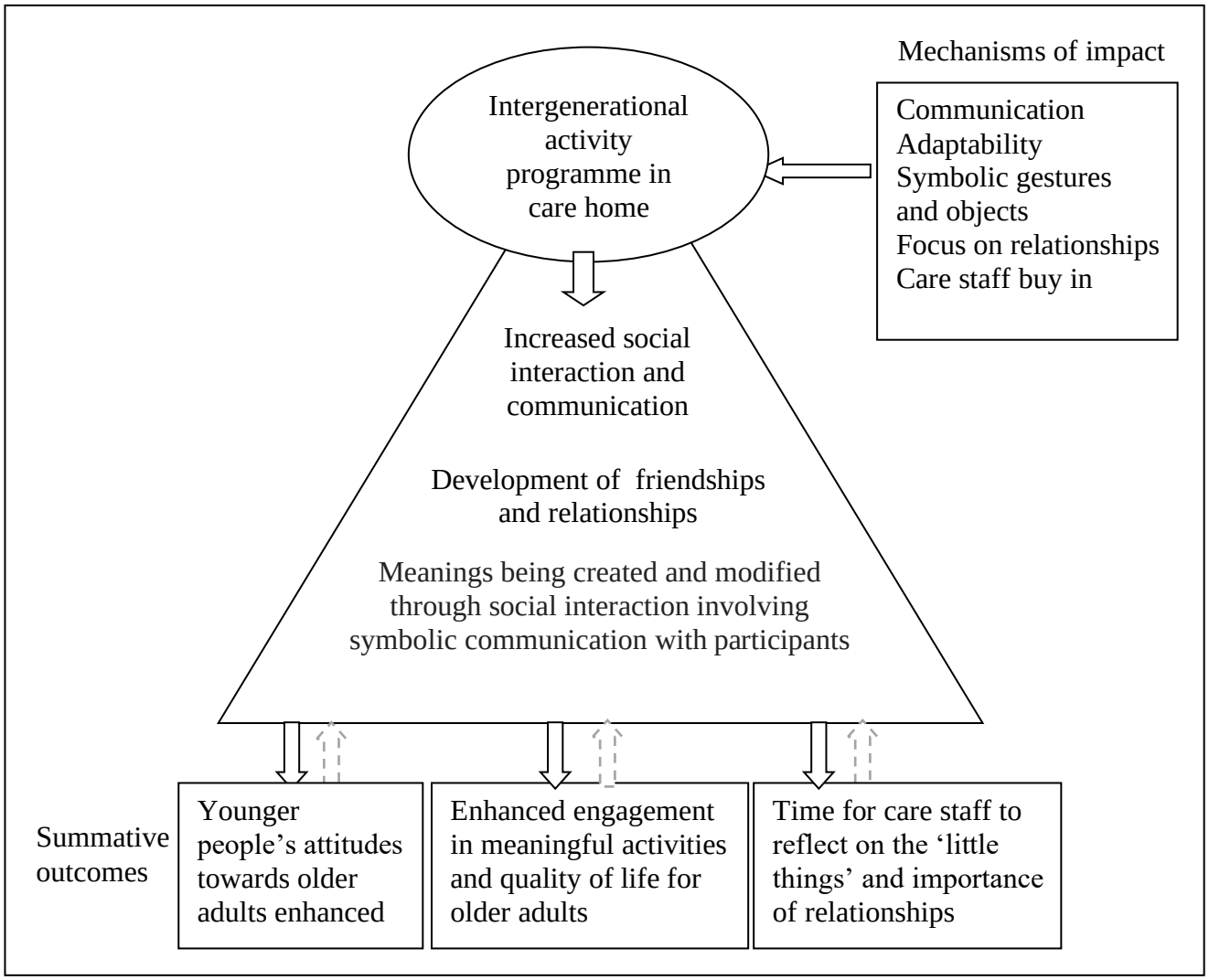
This sense of reward was also evident amongst activity co-ordinators in the non-intergenerational settings. However, their positive comments were often coupled with negative aspects of the work, especially concerning how stressful the job could be, as demonstrated by the following quotes 'Yeah sometimes you can feel overloaded but at other times you feel you're making a massive difference to their lives' (Care home activity co-ordinator, Non-Intergenerational Activity CH, participant 102) and 'Yeah it's a very stressful job and you do take a lot of it home with you, but like I said it's rewarding you know' (Care home manager, Non-Intergenerational Activity CH, participant 2)

7.3. The underlying processes of an effective IAP

This next section pulls together the findings from the process evaluation, exploring how it relates to previous and future research, practice and policy. Unpacking some of the underlying processes that impacted on the effectiveness of the IAP included in this study. A schematic of the findings (Figure 18) depicts interactions between key process evaluation and summative findings and how they are interlinked.

Figure 14

Schematic summary of research study findings



The results of this study suggest that one of the underlying processes of an effective and socially engaged intergenerational programme is adaptability. While initial plans were developed by facilitators, programmes developed and changed as they went along, with actual practices differing from original intentions. This observation was consistent with other research (Granville, 2002; Jarrott, Juckett, et al., 2019; Jarrott et al., 2021; Juckett et al., 2021; K. Lee et al., 2020; Low et al., 2015). This suggests that in order to deliver a successful IAP, facilitators need to take a tailored and flexible approach which can be adapted to different settings and circumstances of particular groups. Having broad themes, rather than specific set activities permitted a tailored approach, and allowed time for the development of more natural engagement and meaningful interactions, that were adapted to the abilities of the participants

in that particular context. Care homes also needed to be flexible and able to shift care and kitchen routines in order to deliver IAP. This is a key feature of best practice of IAP within care homes specifically.

Clear and effective communication between facilitators were also important elements in the success of IAP. Communication played a key role in both planning and overcoming unforeseen circumstance. This study highlighted instances where communication broke down between the facilitators and impacted negatively on the fidelity of the sessions. For example, miscommunication in terms of the number of younger people arriving for the session meant a room was not large enough to fit everyone. Previously, other studies have demonstrated that the care home environment and insufficient space acted as a barrier to engagement in activities by older adults (Bunting & Lax, 2019; Harmer & Orrell, 2008; Kalinowski et al., 2012).. Although space was a factor, it was not the root of problems found in this thesis, as the activities still went ahead. Instead it appears situations could have been avoided if facilitators understood and communicated the limitations of the space. Communication is also key for timing of activities. One care home reported issues around getting certain residents up and ready in time for the activities, similarly some of the sessions altered the time at which lunch was needed to be served and therefore communication with the kitchen staff to alter time lunch is served and for how many at what time was necessary.

From a future practice perspective it is important for activity co-ordinator's or programme facilitators of the intergenerational projects to inform responsible care staff of those residents who are wanting to be involved the day before. This will help to ensure that participants care needs are planned around this. This is particularly important if activity programmes run in the morning when getting residents ready for the day, helping care staff prioritise the order they care for residents and making it easier for all involved. Reshuffling normal routines doesn't need to be arduous, so long as communication is maintained. In this research, many of the intergenerational programmes choose the same day each week and one programme that ran in the morning requested lunch be pushed back or brought forward on that day for the residents taking part. It is these little changes and forms of communication that streamline the running of such activities in care homes, making it more likely that buy in from care staff is achieved.

In line with this, the research found that attitudes of the staff towards activities impacted upon the success of the activity programmes in both settings. Care homes that encouraged and

involved as many members of staff as possible to engage with the IAP, even in small tasks, or popping in for a minute or two just seeing the children and residents interact, impacted on the positive mood amongst the care staff in the care home. Similarly having staff present that were aware of the residents' personal interests, such as, places they had previously been on holiday or occupations they used to have, increased interactions and engagement with the activities and the children. This thesis highlighted that IAP also enhanced staff understanding of the older adults' interests, for example, one resident used to work as a toy buyer in Harrods, and thus loved playing and showing different toys with the younger people. Drawing on older adults previous experiences created connection between participants and enables continuity of the activities the residents used to enjoy and current care home life, something that is found to impact on quality of life and the positive transition into long term care (Sullivan & Williams, 2017).

Support, recognition, and involvement from staff was also essential in order to get residents bathed, dressed and fed in time for the start of the activities. Staff support also had other knock-on effects on the fidelity and success of the activity programmes. This study found that many activity co-ordinators felt that the importance of activity programmes was often overlooked and underappreciated by other care staff, for example, one activity co-ordinator in the IG setting described how other care staff saw them as *'babysitters'*. Recent studies support these feelings reported by activity co-ordinators (Bungay, Wilson, Dadswell, & Munn-Giddings, 2021). Bungay et al (2021) also reported that the role of activity co-ordinators is often 'misunderstood', with their role taken as them being in charge of individually providing all activities across the care home (Hobson, 2019), instead of co-ordinating and shared responsibility to engage residents amongst staff.

This was echoed in this study, activities with the residents was generally viewed as separate to the delivery of care for older adults, something that was also found by Clarke et al (2019) as well as in an intergenerational summer programme (Gigliotti et al., 2005). This disconnect between activity co-ordinators and care staff role was raised by activity co-ordinators in both settings. The attitudes of care staff towards activities was most commonly linked to staff capacity. In both settings the physical care needs of residents seemed to take precedence, care staff engagement with older adults was task orientated and time pressured, limiting the amount of quality time care staff were able to spend developing meaningful relationships and interacting on a one to one basis. Care staff in the non-intergenerational activities in this study

reiterated that they felt they had insufficient time and resources to dedicate to activities despite the recognition of policy recommendations around the provision and delivery of activities within care homes. This was also found by Clark et al (2019). This is perhaps unsurprising, as it is likely that only care homes with sufficient capacity would have agreed to deliver IAP.

Having the younger people present in the care home for a set time each week did however focus the attention of the care staff on the participants involved. It heightened sensitivity and awareness to some of the basic and more meaningful exchanges in life, contributing to creating a sense of security, especially for carers. IAP appeared to appeal and draw in care staff more so than traditional activity programmes in the non-IG activities. With dedicated time each week, as well as the presence of increase number of younger people present in the care homes, IAP enable greater and more meaningful one to one interaction with the residents, which contrasts with the often time poor conditions care staff are faced with when engaging with residents. Buy-in from management also seemed to impact upon the effectiveness of the IAP, with more staff feeling that activities were an integral part of their role. This highlights the potential of IAP as a tool for increasing the recognition of the impact activities and the work the activity coordinators have on the residents. However, this thesis recognises that further work is needed to develop opportunities for more meaningful interactions and proposes intergenerational activities as a way of achieving this in practice. The findings demonstrate that such activities hold promise in altering the ethos around the importance and responsibility of incorporating the provision of activities by all staff across care settings, instead of it being viewed as a separate element of the settings provision.

A recruitment processes that allows everyone the chance to participate is essential to a fully inclusive and socially engaged IAP, that improves connections and communication, promotes meaning and enhances well-being. The researcher was not present during recruitment of older adults to IAP, therefore, it was not possible to establish whether everyone in the care home had an equal chance of accessing or attending the activities. However, it is likely that some of residents who did not regularly attend or show interest in activities prior to the IAP may not have been informed programme, with care staff presuming such activities would not interest them. Elements of this selective nature of recruitment was captured in examples given by care staff who explained how some residents who did not normally engage with residents came to see what was happening from the periphery with little intention of joining in, but gradually started to engage with the younger people as the session went on. Furthermore, care staff spoke

of residents as being suitable or not suitable to part take in the activities, and other residents not wanting them to take part if certain residents with dementia were attending.

This research found that although care staff had limited specific intergenerational training, another key element of successful IAP was enthusiasm and passion. There has been emphasis on the training and leadership skills to help enhance the effectiveness of IAP (Jarrott et al., 2019; Jarrott et al., 2021). The emphasis on best practices and training has raised concerns over the so called 'McDonaldization' of intergenerational work (Kaplan et al., 2009), alluding to a structured skills training approach for intergenerational practice and practitioners. Care staff are already required to undertake a substantial amount of training. However, in this study, enthusiasm and passion played a significant role in the fidelity of activity programmes, in both intergenerational and non-intergenerational settings. Focusing on 'structured training' could potentially threaten the intuitive 'essence' of intergenerational activities.

There have been calls by Kaplan and colleagues to 'pay attention to matters of the heart' (Kaplan et al 2009 p 74). Kaplan, Larkin, and Hatton-Yeo (2009) used the term the *'p'* factor to describe this. The *'p'* factor something that was evident in the implementation of successful intergenerational activities in this study. Interviews with facilitators suggested key members of staff exuberated enthusiasm in relation to IAP. For example, in one care home two facilitators were funded by an external charity organisation to deliver IAP, but more staff participated in delivering the programme with enthusiasm and passion, but who were not required to as part of a formal job or contractual requirements. This points to the need for government funding, to set up a more formal network of intergenerational co-ordinators within the community or local authority to ensure sustainability and less reliance on enthusiastic individuals.

As highlighted elsewhere in a systematic review of intergenerational activities, the commitment of champions is a key factor in the success of IAP (Granville, 2002). This research highlighted that intergenerational activity programmes can still be implemented successfully within real world, complex care environments with relatively little or no intergenerational training. Although this thesis recognises that training might enhance and ensure greater implementation of best practices, as Juckett et al (2021) suggest, it should be approached with caution as it may put care staff off trying to set up new IAP if it becomes mandatory or too formalised. Future research must consider how we can prepare

intergenerational practitioners in a manner that elicits a sense of passion for making a difference in the lives of others.

A simple technique facilitators could use, that was shown to be successful in this study was drawing on the use of different objects such as photos, 'about me' cards, and iPad to facilitate conversations about subjects of common interest. The conversations revealed things participants had common such as travel, playing the piano. Using these tools to spark conversation was largely positive, and often led to a shift away from the task in hand to natural free-flowing conversations. However, in some instances the tools used in IAP were barriers to meaningful activities. Lokon et al. (2012) found that youth sometimes had difficulties establishing the right balance between helping older adults with dementia and completing the task themselves. Evidence of this was found in this present study, as care staff reported they had to step in when the younger people were involved in sessions using iPads. On occasions younger people were outpacing the older adults; They were doing activities *for* residents, instead of doing it along with the resident, at a pace where information or things they are showing the resident could be comprehended and fully understood. Outpacing is an element of malignant social psychology and dementia care suggested by Kitwood (2005) which could be detrimental to that individual's '*sense of self*'. Kitwood (2005) argued that whilst most people do not outpace people living with dementia deliberately, it still can have negative effects on the person.

Whilst younger people frequently demonstrated an ability to grasp the needs of the older adults as mentioned previously (in relation to affective and caring behaviours), this example suggests that they were less attuned to the needs of older adults in relation to technology. The younger people in this study were likely to have had access to ICT (iPads, smart phones) from an early age and have grown up using these technologies. They may be less aware that older people have spent a substantial part of their lives without such technology and are not so familiar with the rapidly evolving world of ICT. ICT tools in this study were highlighted as symbols of generational difference which is in line with previous research (McDaniel, 2002), and something that needs to be considered in the training of younger people engaging in ICT based IAP. In response to this, using alternative techniques such as recognition, negotiation, and collaboration (see below) could encourage more *'positive person work'* to ensure older adults feel valued and included.

Some IAP facilitators did demonstrate elements of Kitwood's positive person work in response to some of the younger individuals who were outpacing the older adults. The facilitators highlighted the 'outpacing' behaviours younger people were displaying to the older adults (recognition) and encouraged the students to say or ask the residents what they wanted to get from the session (negotiation). They also prompted the children to start 'tutorials' from the beginning, so that they could help older people understand basic activities such as turning on the computer (collaboration), rather than doing it for them. This approach reflected elements of positive person work as well as elements of best practice that is, guiding the activity to promote IG interaction and responsive to both generation of participants, whilst avoiding over facilitation (Jarrott et al 2019). Aspects of '*positive person work'* is something that could be incorporated into training for IAP facilitators to ensure they are able to make younger people aware of the needs of the older adults and steer the activities away from potentially detrimental impacts.

One of the other important underlying mechanisms of effective IAP revealed by this study was the creation and exchange of symbols and artefacts. Often relocation to long term care necessitates relinquishing valued and meaningful possessions in order to be accommodated in a smaller living space (Sullivan & Williams, 2017). However, personal possessions can help to maintain a sense of identity. Possessions have the effect of 'keeping alive the moment they became ours' or can be used to recall events in our lives (Green & Ayalon, 2019, p. 577). In this study, the 'symbols' of participation in intergenerational activities were interpreted in the context of aiding reminiscence and were used to explain the sustained enhanced quality of life for residents beyond the end of the programme. This suggests that it was not just the 'in the moment' interaction between younger people and older adults that was important, but that there were other mechanisms that helped sustain impact. The results suggested that symbols and artefacts linked to the intergenerational activities - either created in the session or received as a result of the relationships formed from the sessions - acted as part of that trigger for remembering the relationships formed in the intergenerational activities. There was no evidence to suggest that such symbols generated in other activities (e.g. in non-intergenerational arts and crafts sessions) had a similar impact.

The creation of artefacts that act as symbols of intergenerational activities has received limited attention in previous research, except for one intergenerational project in Stoke on Trent which observed that younger people 'created drawings and doodles to express the value of the social

benefits of the project'. Researchers in this study also noted that 'the closure of the project appeared to bring with it a desire to create lasting memories and offer something to the people with whom connections had been made' (Wright-Bevans, 2017, p. 301). New possessions particularly those acquired by the older adults, appeared to act as a positive emotional trigger, sustaining effect beyond the period of activity. For example, when care staff or family members or friends entered the older adult's rooms it was likely to spark conversation and prompt residents to recall about the activities. Further to this, some artefacts and objects brought into the IAP were created or organised by younger participants in their own time. They drew on others such as parents to help negotiate this process, demonstrating impact of sharing of experiences and symbolic meaning beyond the care home and into the community.

7.4. Chapter summary

A number of key themes were extracted from the qualitative data, many of which were interlinked. These included enhanced quality of life and meaningful engagement, changes in attitudes and understanding between stakeholder groups, as well as the development of meaningful and quality interactions. Symbols of meaning were also found to be associated to positive outcomes and sustained the impact IAP had on participants. Care staff across both settings identified time and support from other care staff as a barrier to fully engaging residents in meaningful activity. Whilst intergenerational activities appeared to capture older adults, younger people and care staff interest, the results highlighted cultural issues such as care workers perceptions of their role in the delivery of activities that influenced the provision of activities across both settings. These findings are discussed in further detail in the discussion section and section 9.2.

8. Chapter Eight - Summative Evaluation

This chapter discusses the findings of the summative evaluation. Firstly it presents the quantitative results of the questionnaire data for each of the stakeholder groups. It then goes on to discuss the implications and qualitative interpretation of these findings in relation to the wider impact of these on the participants.

8.1. Older adult outcomes

The impact of activities for older adults focused on the outcomes quality of life, depression, feelings of loneliness, perceived engagement in meaningful activity and self-assessed health status. The mean scores and standard deviations for all of these outcomes measures are presented in table 14, with more detail on these outcomes measures findings discussed in the following section.

Self-reported quality of life (DEMQOL)

The primary outcome was quality of life of the older adults as measured with DEMQOL. After controlling for baseline differences results demonstrated a significant main effect of setting (intervention vs active control) $F(1, 92.97)=4.37$, $p=.039$ and effect of the interaction time by setting $F(2,81.51)=3.46$, $p=0.036$ and setting by age $F(1, 90.82)= 6.23$, $p=.014$. Pairwise comparisons of the DEMQOL means defined by the group (i.e. intergenerational vs active control) by wave interaction wave showed the following: 1) there were no significant differences in DEMQOL at baseline $F(1, 92)$, 0.482, $p=.489$) however, there were differences in DEMQOL at 6 weeks $F(1, 90.27)=10,48$, $p=.002$ and 3 months $F(1, 89.56)=12.35$, $p=.001$ with older adult care home residents in the intergenerational intervention group demonstrating greater levels of quality of life than those in the active control group. The difference between the mean quality of life scores between the two groups increased over time (Figure 15).

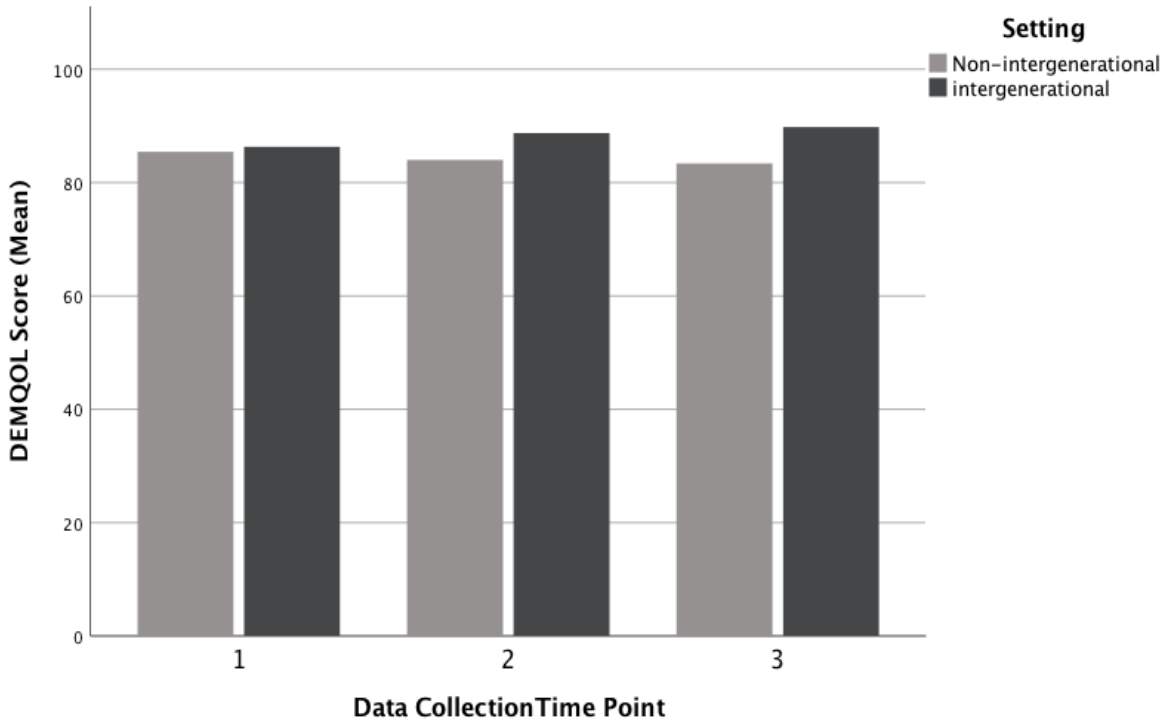
Table 23

Mean scores and standard deviations for OA outcomes across time points

	Baseline (T1)				Week 8 (T2)				Week 12 (T3)			
	IG		Non-IG		IG		Non-IG		IG		Non-IG	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Quality of life	86.76	7.72	84.76	6.70	90.27	7.86	83.80	7.71	90.12	7.78	83.27	7.48
Engagement in meaningful activity	26.05	4.62	26.32	3.44	28.34	4.59	26.41	3.29	26.76	5.02	26.46	3.35
Depression	4.37	2.34	5.27	2.12	4.54	2.68	5.46	2.32	4.51	2.52	5.51	2.54
Self-assessed health status	3.34	0.79	3.35	0.73	3.51	0.74	3.51	0.71	3.54	0.84	3.56	0.87
Loneliness	3.10	1.62	3.39	1.50	2.95	1.55	3.73	1.51	2.98	1.71	3.68	1.51

Figure 15

Mean DEMQOL scores by time and setting

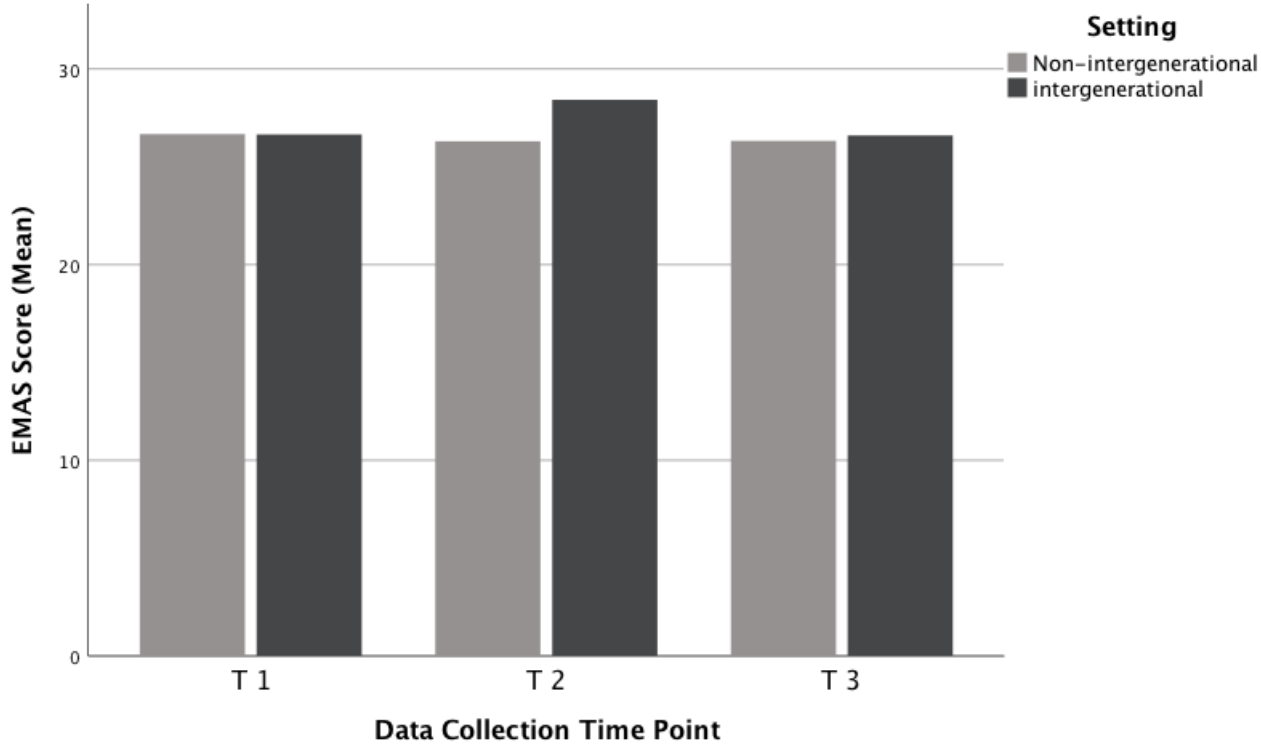


Engagement in meaningful activity (EMAS)

There was a main effect of time (T1, T2, T3) F(2, 82.56)=3.76, p=.027 and effect of the interaction time by setting F(2,82.56)=6.01, p=0.04. All other effects or interactions with EMAS mean scores were non-significant. Pairwise comparisons of the EMAS means defined by the group (i.e. intergenerational vs active control) by time interaction found that prior to the start of the activity programme there were no significant differences in EMAS at baseline F(1, 93), 0.855, p=.840). Analysis revealed there was however differences in EMAS between settings at 6 weeks F(1, 86.98)=0.840, p=.047. Differences in engagement in meaningful activities between settings were not sustained, with no significant difference in EMAS between settings at 3 months F(1,86.52)=.006, p=.940. Differences across time in the intergenerational setting were also found between T1 and T2, F(2,81.33)=.9.84, p=.002. The older adult care home residents in the intergenerational intervention group displayed greater engagement in meaningful activity than those in the active control group, with meaningfulness of activities in the intervention group increasing from T1 to T2 (Figure 16).

Figure 16

Mean EMAS scores by time and setting



Levels of self-report depression (GDS)

The were no fixed effects of time F(2, 194)=.52,3 p=.594, setting F(1, 97)=1.61, p=.208, or age F(1, 97)=1.41, p=.071 on GDS score. Additional there were no significant interactions. Pairwise comparisons demonstrated no significant differences of GDS between settings at baseline (T1) F(1, 93)=.738, p=.393, at T2 F(1, 87.81)=.371, p=.544, or T3 F(1, 89.33)=.575, p=.450.

Self-assessed health status (SAHS)

Analysis found no fixed effects of time F(2, 84.61)=2.73, p=.071, setting F(1, 90.42)=.001, p=.971 or age F(1, 87.96)=.377, p=.541 in relation to participants self-assessed health (SAHS). There were no significant fixed effect interactions between SAHS and time, age or setting. Pairwise comparisons of the SAHS means defined by the group (i.e. intergenerational vs active control) by time interaction found that there was no significant differences in SAHS at baseline over time F(2, 84.105)=2.68 , p=.074) or between settings F(1,90.377)=.001, p=.978.

Loneliness (LONE)

Analysis showed no fixed effects of time F(2, 83.56)=1.23, p=.297, or setting F(1, 92.13)=.2.61, p=.110 on loneliness. Age as a co-variate did however show an effect F(1, 89.86)=5.98, p=.016. Pairwise comparisons found LONE means defined by the group (i.e. intergenerational vs active control) by wave interaction wave showed there were no significant differences in the intervention and active control LONE scores at baseline F(1, 93), 0.594, p=.443) and at T3, F(1,89.35)=2.39, p=.125. Loneliness scores in the active control group did decrease compared to the control at T2 but however this again was non-significant F(1,90.22)=3.84, p=.53.

8.2. Care Staff outcomes

Outcomes for standardised questionnaires in relation to the care staff involved included job satisfaction, job empowerment, attitudes to dementia, and job strain. Mean scores and standard deviations are included in Table 24.

Table 24

Mean scores and standard deviations for CS outcomes across time points

	Baseline (T1)				Week 8 (T2)				Week 12 (T3)			
	IG		Non-IG		IG		Non-IG		IG		Non-IG	
	n	*SD*	*n*	*SD*	*n*	*SD*	*n*	*SD*	*n*	*SD*	*n*	*SD*
Job Satisfaction	80.71	11.66	83.35	10.23	82.32	11.93	81.82	9.19	81.43	12.10	80.76	8.91
Job Empowerment	83.06	8.11	45.12	7.58	44.21	6.60	44.71	8.45	43.7	6.8	43.29	7.61
Attitudes to Dementia	83.71	8.14	83.06	8.22	84.50	8.49	82.06	8.12	84.64	8.36	82.35	7.85
Job Strain	88.74	37.96	107.47	37.11	96.21	47.36	103.93	38.22	93.72	43.88	106.80	35.82

Job Satisfaction (MJS)

Results from a mixed linear model analysis revealed that there was a non-significant main effect of setting (intervention vs active control) F(1, 48.626)=1.067, p=.307, time F(2,42.865)=.638, p=.533 and effect of the interaction time by setting F(2,42.865)=.457, p=.636.

Attitudes towards dementia (ADQ)

There was no main effects of time F(2, 43.40)=.250 p=.780 or setting F(1, 48.78)=1.269, p=.266 on attitudes of care staff towards dementia. Also there was no significant interaction effect of time with setting on attitudes to dementia F(2, 43.40)=.090, p=.914.

Job Empowerment (CWEQ-II)

Results from a mixed linear model analysis revealed that there was a no main effect of time F(2, 43.09)=4.198, p=.222, or setting F(1, 48.74)=1.56, p=.217 and effect of the interaction time by setting F(2,42.865)=.457, p=.636. was also non-significant on job empowerment of care staff.

Job Strain (SDCS)

There was no main effects of time F(2, 47.71)=.898 p=.414 or setting F(1, 50.33)=354, p=.555 on job strain. Also there was no significant interaction effect of time with setting on attitudes to dementia F(2, 47.71)=.2.33, p=.108.

8.3. Younger People Outcomes

This section discusses findings in relation to younger peoples scores on the Children's Attitudes Towards Elderly Scale (CATE). Table 25 presents the mean scores and standard deviations across all three time points.

Table 25

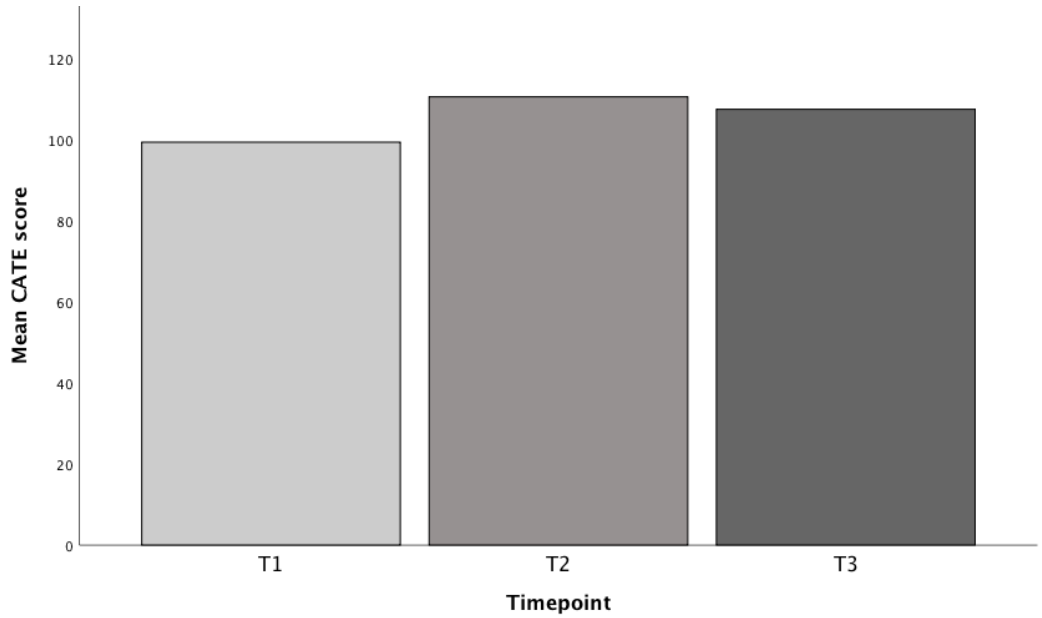
CATE Mean score and standard deviations across timepoints.

	Timepoint 1 (T1)		Timepoint 2 (T2)		3 Months (T3)	
	n	*SD*	*n*	*SD*	*n*	*SD*
CATE	99.47	0.93	110.64	1.10	107.58	1.18

Results from a mixed liner model analysis revealed a significant main effect of the overall CATE score and time F(2,94.292)=61.928, p=<0.001 on the CATE score. Pairwise comparisons also showed significant effects of time from T1 to T2 F(2,94.28)=61.928, p=<0.001 and T2 to T3 F(2,94.036)=61.92, p=<0.001. This along with the mean scores and SD in table 19 demonstrates that younger people's attitudes significantly increased from T1 to T2 but then the drop in attitudinal scores from T2 to T3 was also signifgicant, meaning younger peoples attitudes towards older adults following the IAP were not sustained. This is highlighted in Figure 17. Pairwise comparisons showed no significant affect of time by age F(2,93.46)=.488, p=.615.

Figure 17

Mean CATE score across timepoints



8.4. Impact of IAP on residents, younger people and staff

IAP research exploring engagement and outcomes in relation to outcomes for people living in care homes and more specifically those with dementia in long term care have been shown to be feasible, with residents able to consistently engage over several weeks or months despite any decline in function (Lee et al., 2007). However, research into outcomes for residents associated with participation in IAP is limited, with many evaluations being of low quality. Many studies looking at quality of life as an outcome from intergenerational activities in care settings reported anecdotal evidence (Gigliotti et al 2005; George, 2011), a few had reported improvements in quantitative quality of life outcome measures (Chung, 2009).

This thesis demonstrated that there were changes in two of the five outcomes assessed pre- and post IAP with older adults, which included feelings of loneliness, depression, engagement in meaningful activity, quality of life and self-reported health status. No significant changes were found over time in any of the outcomes with older adults in the control setting. Previous research identified a number of key areas that influenced quality of life, many of which were directly relevant to elements of IAP. These included being useful and being able to accomplish something meaningful (Dröes et al., 2006; Moyle et al., 2015); relationships with family and community; and participating in activities and therapies (Murphy et al., 2007; Tester et al., 2004). Furthermore, non-kin relationships were especially important for residents who had no family or whose family no longer visited (Moyle et al., 2011).

Older adults that engaged with intergenerational activities had significant enhanced self-reported quality of life as measured by the DEMQOL compared to those in the active control group. These results support an array of anecdotal qualitative evidence that has reported the positive impact of IAP on aspects of older adults lives, and quality of life in particular (Doll & Bolender, 2010; George & Singer, 2011). They do however conflict with findings from Low et al's (2015) study which found no significant changes in quality of life for participants in the Grandfriend intergenerational programme. Differences in results may be due to the use of different measures to capture quality of life and/or differences in the size of the study population. The present study used DEMQOL, whereas Low et al.'s study used the long term care quality of life scale. The use of different quality of life measures across studies focusing on quality of life of residents in care homes is something that has been highlighted in previous literature reviews limiting the ability to make cross study comparisons (Sullivan & Williams,

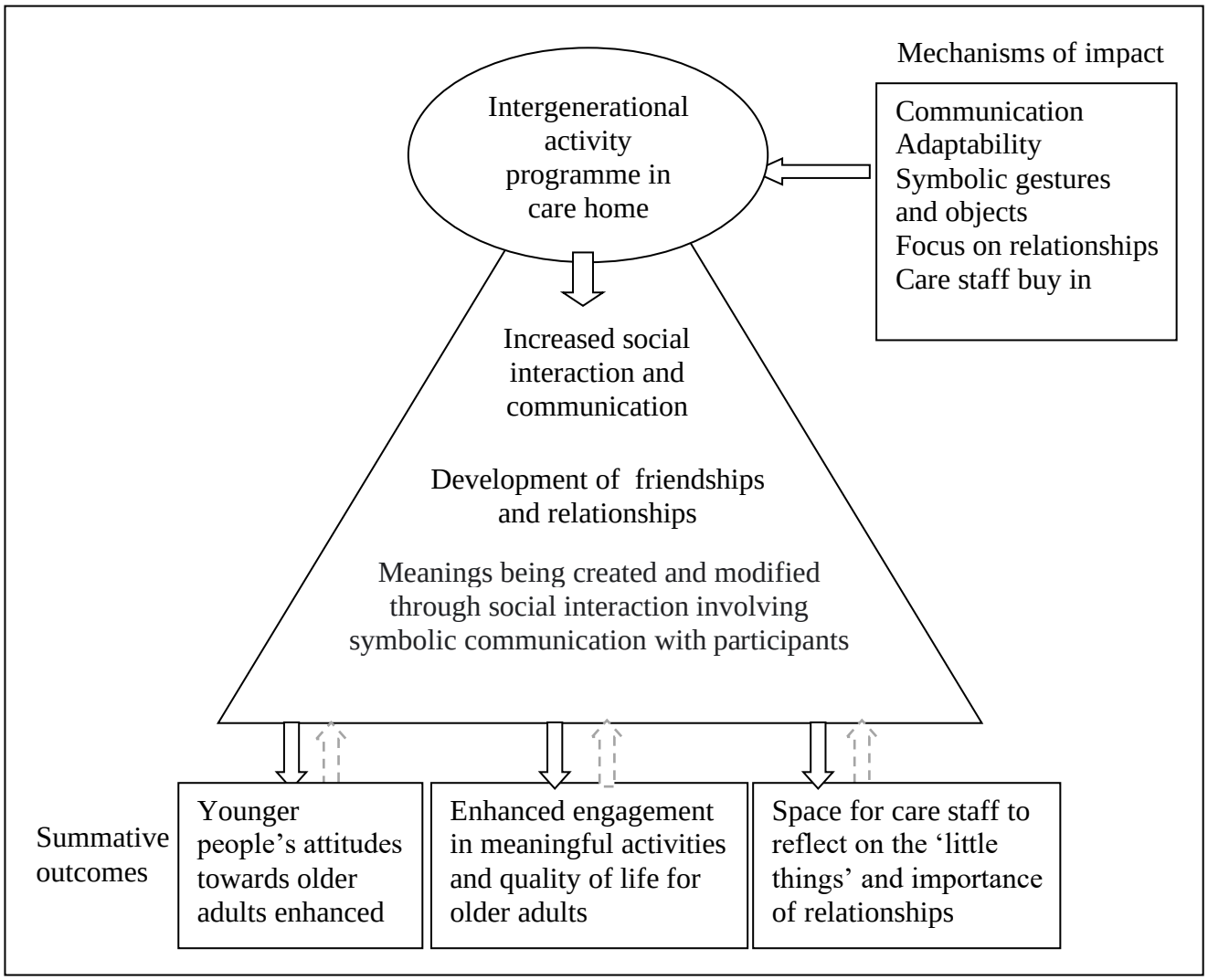
2017). Furthermore, Low and colleagues sample of residents was smaller than the present study (N=40 to N=96 respectively) limiting the power of the study to detect change in quality of life. It was clear from the literature review that social relationships and interactions are key, with the social benefits of IAP having been well documented (Springate, Martin & Atkinsons 2008; Granville, 2002; George, 2011). Consistent with this body of literature, one of the key outcomes from the current study was the development of meaningful relationships and friendships formed between the older adults and younger people. This was at the heart of intergenerational activities but not central to traditional activity programmes. During the intergenerational activities older adults and younger people use different methods to communicate, including expressive verbal language, altruistic gestures, positive body language such as facial expressions and hugging, and physical objects – these verbal and non-verbal symbols communicate meaning. Many care staff reported 'beaming smiles', laughter and nurturing behaviours demonstrated by older adults when engaged in the IAP, compared to the control setting. Such forms of positive body language were also observed in other studies, for example, in the 'Adopt a Care Home' programme (Di Bona et al., 2019). Relationships were formed as a product of everyday interactions of individuals. The exchange of positive language and conversations the older adults had about the intergenerational sessions, shed light on the potential influence intergenerational activity programmes may have in achieving age friendly communities, in particular about ways in which social participation can facilitate respect and social inclusion.

The quality of friendships and relationships, and the speed at which these were formed came as a surprise to many of the care staff, despite prior concerns about how different generations would interact. In this present study, the focus of the control group was on the activities themselves, whereas participants in the IAP group focussed more on interactions and the social aspect of the programme. This was demonstrated in the semi-structured interviews with the older adults who frequently used storytelling to express their enjoyment of the intergenerational activity programme. Similar findings were also highlighted in a recent study by Wright-Bevans (2017) where participants in the intergenerational settings rarely, if at all, spoke about the specific nature of the activities. Instead, focus was on the individuals involved and the value of the relationships had brought to them. This was less apparent in interviews with older adults from the non-intergenerational settings. It is likely that these meaningful social relationships demonstrated by participants in IAP enhanced the quality of life of older adults living in care settings. This is consistent with other research with older adults that has demonstrated the

significant role relationships play in quality of life (George & Singer, 2011; Meeks & Looney, 2011). A schematic of the findings (Figure 18) depicts interactions between key process evaluation and summative findings and how they are interlinked. While this study provides a framework of the findings in this study, intergenerational activities and the impact they have on individuals will inevitably vary, in line with symbolic interactionism that intergenerational relationships are open to interpretation and individuals own assignment of meaning and intentions, thus outcomes are not limited to just these captured in this study. This reflects a limitation of this study in that gatekeepers selected those that were most likely to want to engage with such activities. The intergenerational literature would benefit from further exploration of attitudes of those that did not wish to engage in such activities.

Figure 18

Schematic summary of research study findings



These findings suggest that if intergenerational activities are to be successful and sustainable in future practice, they must avoid being reductionist in nature, shifting away from being subject orientated to more relationship orientated, nature much be taken by facilitators of intergenerational activities, something that is supported by Sanchez (2018).

Other studies have found a significant positive correlation between engagement in meaningful activities and quality of life (Goldberg, Brintnell & Goldberg, 2002). This study found that in line with improved scores on the self-reported quality of life, EMAS scores also improved significantly across the course of the IAP in comparison to those in the non-intergenerational setting. Findings from the qualitative interviews suggest that enhanced social interactions between older adults and younger people enabled the development of meaningful relationships and friendships between participants, which acted as a key driver for the success of intergenerational activities (Figure 18). This development of meaningful relationships was also found to be central to a recent intergenerational ballet programme with individuals living in long term residential care (Canning et al., 2020) and by Gigliotti and colleagues (2005) where special attachment bonds between certain older adults and younger people were said to formed. Contact theory is often drawn upon explain findings in relation to the attitudinal change and development of relationships often associated with IAP, as a result of two groups coming together with equal status and common goals (Jarrott & Smith, 2010). Whilst this present research found evidence to support a shift in attitudes and understanding amongst younger people, the results also suggest that instead of 'contact', what was most prominent in relation to the intergenerational activities (and compared to non-intergenerational activities) was the development of friendships and the meaning and value of the activities to individuals.

This study indicated no significant change of feelings of depression, between pre, post and follow up results in both settings, indicating the relative stability of the older adults' mental health over time. This result was consistent with other intergenerational studies that used GDS as an outcome (Skropeta et al 2014) or different measures of depression such as the Beck Depression Inventory (George & Singer, 2011). The results of the present study conflict with a Chinese study which demonstrated a reduction in depression scores (GDS) across the 12 weekly intergenerational reminiscence sessions (Chung et al 2009). However, assessments were completed by a proxy, meaning the voice of the those with dementia was not included. Additionally, there was no control groups in the design, thus limiting the ability to attribute

changes in outcome measure to specific aspects of the intergenerational exchange. Self-assessed health and loneliness scores of older adults reported across the course of the study and between settings, also showed no significant changes across the course of the study.

Younger people demonstrated a significant change in their attitudes towards older adults having taken part in the intergenerational activity programme. However, positive attitudinal scores started to dip at the 3 month follow up; 4 weeks after the cessation of the intergenerational activity programme. One of the most commonly reported social outcomes of intergenerational activities in the published literature was a positive impact on the attitudes of younger people and older adults towards each other (Cadieux, Chasteen, & Packer, 2018; Caspar, Davis, McNeill, & Kellett, 2019; Mendonça, 2018; Levy, 2018). In this study, many of the initial negative stereotypes of older people held by younger people changed over the course of the IAP. Younger people's score on the CATE questionnaire improved significantly between the start of the IAP and the end of the end of the IAP demonstrating more positive attitudes towards older adults (Figure 18). These findings link to RQ1, and suggest that involvement with an intergenerational programme delivered in a care homes does have the power to alter attitudes of younger people towards older adults for the better. Open-ended responses to CATE saw a clear shift from negative physical responses to more positive behavioural and affective descriptions. This effect, however, was less pronounced in the youngest individuals, who still drew on physical descriptions of the appearance of older adults towards the end of the IAP over and above more behavioural and affective descriptions. Overall, average CATE scores started to dip at the 3 month follow up, which suggests that the effect of intergenerational activities on attitudes was not sustained.

Negative attitudes are often deeply rooted within cultures and contexts, therefore whil short term attitudinal change may be associated to younger people's perceptions of older adult participants from the IAP specifically, it cannot be concluded that more deep-rooted attitudes remain influenced by larger external macro contexts. It is therefore important not to overstate the degree of social change that can occur in such a short space of time. Through a symbolic interactionist lens, more repeated interactions were necessary to sustain more deep-rooted changes to younger persons subjective attitudes. In addition to this, attitude change perhaps could be sustained by the creation of more symbolic objects from the session, which younger people could draw on following the cessation of the sessions to remember the events and the attitudes they held towards their older companions, and/or prompts to seek out opportunities to

encounter older adults in their everyday lives. IAP may act as the impetus and catalyst for more meso and macro level change in creating age friendly communities from within care homes and beyond.

Improvements on CATE scores by the end of the IAP, were mirrored in the affective and sympathetic behaviours younger people displayed towards older adults. These were described by facilitators and older adults. For example, in an unprompted gesture, one young girl wiped saliva from the mouth of a resident who had a stroke, and a boy held the door open for a gentleman in a wheelchair. These actions relied on the younger people's intuition and demonstrated an understanding of the older adults needs and abilities. IAP created environments that seemed to evoke and draw out caring and compassionate behaviours amongst many of the younger participants towards the older adults, such behaviours may have been as a result of as '*learned behaviours'* from being in the care home context. Overall, and consistent with previous studies (Di Bona, 2017; Atkinson & Bray, 2013; Galbraith et al., 2015), levels of comfort in each other company, and the relaxed nature of interactions and affective behaviours demonstrated by both older and younger participants gradually increased as the programmes progressed. Some younger people may not have had similar encounters outside of the IAP, thus, the programme broadened their experiences and helped them to form positive memories of the care settings and older adults. IAP seem to bring some fundamental things in life to the forefront, heightening awareness of meaningful social exchanges and the importance of these.

Whilst care staff in the intergenerational settings were highly positive about activities, the study found no significant changes in job satisfaction scores in either setting. Qualitative findings did however reveal enhanced sense of purpose and fulfilment, predominantly amongst activity co-ordinators and facilitators when delivering the activity. As with older adults involved in the IAP, care staff seemed to be more focused on the meaningful interactions that occurred during the IAP. Responses from semi structured interviews with care staff highlighted the feelings of reward they got from their job in the context of the activity programmes.

The task-focused nature of care provision was particularly dominant in the non-intergenerational activity settings, where care staff appeared to become desensitised to what they experienced on a daily basis. However, care staff in non-intergenerational setting did refer to positive and negative moments that were woven throughout their daily job roles: *'the little*

things' which perhaps upon reflection and through another person's eyes might be deemed quite poignant. On the other hand, having younger people present heighten sensitivity to the sense of purpose that care staff felt in their role, and helped them reflect on older adults experiences of care they receive during the course of the IAP. In addition, the different characteristics that some older displayed when they were interacting with younger people helped care staff to rethink how they had characterised certain residents, with elements of surprise expressed by care staff, in relation to participants behaviours. This was reflected in the mechanisms of symbolic interactionism whereby care staff renegotiated the identities of residents in light of what they observed in the IAP, and internalised these new 'versions' of the resident, which challenged their previous conceptions. In order to further relationship based practice and policy, intergenerational activities may be a vehicle for altering care staff perspectives towards the importance of such age friendly approaches and embedding senses framework within care homes across Wales. Although more work is needed to explore this relationship between staff perspectives of activities generally and relationship centred care.

The type of activity delivered was not essential to the underlying processes that led to effectiveness of IAP, e.g. card making, singing did not appear to affect outcomes. This finding was consistent with previous research (Galbraith et al., 2015). Instead, the development of meaningful relationships, and the development of artefacts that lent themselves to story recall and social interaction had an impact on outcomes in IAP. Objects and gestures associated with the intergenerational activities acted as the catalyst for conversation, revealing things participants may not have found in common, without a tool to start communicating. Symbolic interactionism assumes that we alter the way we behave towards others and adjust our approach depending on how we believe others perceive us. Interactions between participants were influenced by subjective meanings and exchange processes throughout the course of the activity programme. Furthermore, in contrast with iPads (which were a symbol of generational difference), artefacts produced during and after IAP were used as symbol to develop shared narratives that reminded those involved that the residents had been connected and socially active. Conversations were internalised by the residents and reinforced the sense of well-being derived from the 'in the moment' interactions which reflected similar findings immediate improvements of positive affect following IAP (Baker et al., 2017).

In relation to personalities of the younger individuals selected, the way younger people presented themselves to teachers may have influenced whether or not they get selected for the

programme, similarly the concept of shyness is a perception of other people from other people's reflection about a person's social characteristics. This influence of personalities impacting upon the IAP was also found in Di Bona and colleagues adopt a care home project based in Sheffield, UK. In this study staff reported they had to be 'intentional' with the pairing up of OA and YP in order to maximise positive interactions.

8.5. Chapter summary

This chapter presents findings from the summative evaluation. The results covered individual outcomes for each stakeholder group, factors influencing activity programme implementation as well as factors influencing individual outcomes. The quantitative data from administered and self-administered questionnaires found three significant results,

These included an increase in quality of life scores from T1 to T2 and T2 to T3 amongst older adult participants in the intergenerational activity programme. Younger people demonstrated a significant improvement in their attitudes towards older adults having taken part in the intergenerational activity programme. However positive attitudinal scores started to dip at the at T3. follow up. While staff were highly positive about the experiences in intergenerational settings, the study found no significant changes in job satisfaction over time between in either setting. The findings are triangulated and discussed in more detailed in the following discussion section.

9. Chapter Nine – Discussion

This research is one of the first evaluation in Wales that lays foundations for informing the value of care staff in IG, which is usually not identified in policy. This research has shown that there are range of different impacts that intergenerational activity programmes in care homes can have on older adults, younger people and care staff, when compared to non-intergenerational activity programmes. Further exploration of both the quantitative and qualitative outcome findings are discussed below. The results of this study highlighted that care homes needed sufficient flexibility to allow them to deliver IAP, and that good delivery was mediated with good communication, a good facilitator and buy-in from management and staff. Artefacts and symbols related to IAP were also shown to be a tool for influencing the success of the intergenerational activities.

The overall aim of this thesis has been to explore the extent to which intergenerational programmes change, sustain and catalyse cultures, beliefs, attitudes and behaviours to create age-friendly care home environments. Whilst intergenerational activities in care homes are not a new concept, this study looked at the real-world implementation of intergenerational activity programmes in care homes, using a living lab approach. It sought to address the following research questions:

RQ1: Can changes in (1) quality of life of older residents, (2) attitudes of younger people; (3) care workers' job satisfaction; and social engagement between all of these groups be demonstrated through participation in, or involvement with an intergenerational programme delivered in a care home

RQ2: What are the underlying processes of an effective and socially engaged intergenerational programme that improves connections and communication, promotes meaning and enhances well-being?

RQ3: Can the implementation of intergenerational programmes make a central contribution to sustainable relationship-centred social care and the creation of age-friendly communities in care homes?

The discussion reviews and synthesises the qualitative and quantitative findings from both summative and process evaluations, positioning the current findings within the extant body of literature, policy and practice, presented in previous chapters. By doing so, the research findings are triangulated. The triangulated data are used to explore the impact that the activity programmes had on each of the stakeholder groups. In doing so, it considers the implications for future intergenerational research and practice. Throughout this chapter, consideration is given to the overall contribution IAP can make to more relational orientated approaches to care and the creation of a care environment fit for all ages.

9.1. The contribution of intergenerational activities to care environments

This research set out to establish whether IAP could make a central contribution to sustainable relationship-centred social care and the creation of age-friendly communities in care homes. To date, there has been little research on creating age friendly communities within care homes, and to the researchers knowledge, no studies exploring the potential for intergenerational activities contribution to the creation of such communities. The new Age Friendly Wales Strategy (Welsh Government, 2021) has been subject to amendment by the Deputy Minister for Health and Social Services, adding a greater emphasis on the importance of 'encouraging intergenerational support' and something that findings can support and endorse.

Age friendly communities are intended to ensure all individuals are fully supported to live socially, culturally and environmentally included as they age (World Health Organisation, 2007). This research suggests that IAP can contribute to the creation of age-friendly communities within care homes. It has demonstrated that IAP in care homes can help encourage and create spaces which foster three of the eight domains in the World Health Organisation (WHO) age friendly environment mode (i) social participation (ii) respect and social inclusion and (iii) communication and information.

With regard to social participation, findings suggested that IAP can help bring participants together: activities were the foundations from which interests, believes and values were shared, and mutual interest and experiences were recognised. With regard to respect and social inclusion, and in relation to the younger people who took part in the IAP in this study, there were significant changes in younger people's attitudes towards older adults. IAP enabled a positive exposure to care environments that challenged younger people's preconceived ideas

of a care home. Instead, they created environments which elicited self-directed altruistic and caring behaviours demonstrated by many younger participants towards the older adults.

These outcomes, along with the fact many of the younger people reported that they had learnt about dementia, contributed to creating age friendly communities. This is something that should be built upon by the Welsh Government if it is to continue its work aligned with Age friendly Strategy; Intergenerational activities show promise in the longer term generational shift of attitudes away from ageist societies, however this will not happen unless funding and additional support if provided for intergenerational opportunities to be created.

This research suggests that relationships and social interaction, especially between different generations, play an important role in engagement in meaningful activities and subsequent self-reported quality of life of older adults. While this research cannot prove a causal link between engagement in meaningful activities that are built around social connections and enhanced quality of life as measured in the intergenerational settings, other research has explored such social connections and proposed social connection as a form of prescription to improving health and well-being (Martino, Pegg, & Frates, 2015). This indicates that intergenerational activities might be one way in which individuals in care settings can increase meaningful social connections, with potential to alter the quality of life of its residents.

The symbolic interactionist perspective began to emerge from the data, and helped the researcher shed light on how changes in relation to different stakeholder groups may have occurred and be sustained as a result of the symbolic interactions and exchanges in the intergenerational programme.

The creation and exchange of artefacts and gestures that act as ‘symbols’ of intergenerational activities and the importance of meaning associated to these by participants, has received limited attention in previous research. In the present study, the new objects appeared to act as a positive emotional trigger, potentially sustaining the effects beyond the period of activity. This was further reinforced when care staff commented on objects from the activities in the residents room. Some artefacts and objects brought into the IAP were created or organised by younger participants in their own time, drawing on others such as parents and guardians to help negotiate this process.

This research also starts conversations towards thinking about the wider implications of IG in social care and the workforce within care homes. Aligned to principles of relationship centred care, a key aim of the social services and wellbeing act, was to 'shift the focus of the workforce and professionals engaged in social care from a task-based approach to a focus on well-being outcomes for people' (Verity et al., 2020). IAP holds promise in shining light on the ability to create spaces which allowed care staff to reflect and recognise the importance of social connections and 'what matters' to people who use services, carers, and communities. Although activity co-ordinator facilitators in this programme had limited specific intergenerational training, enthusiasm and passion amongst certain individuals in organisations was a key element of successful IAP. The importance of staff in enabling the residents to take part and their attitudes towards the intergenerational activities were also highlighted.

The majority of care providers are grappling with growing continuing care costs and staff retention. While having passionate individuals for these types of programmes within care homes is a clear benefit, it also highlights the vulnerability, and the influence of austerity and political agenda in the way initiatives are organised by enthusiastic volunteers and individuals over and above their already stretched roles. This has knock on effects in relation to the sustainability of intergenerational activity programmes, holding individuals and institutions responsible for implementing intergenerational practice, often with limited funding. These findings support the benefits associated with such activities and offer a case to government for additional funding to set up dedicated intergenerational co-ordinators within local authorities. This would provide the additional support needed to fulfil their advocacy of such practices within policies.

Intergenerational activities also provide opportunities for shared resources and sustained interactions within care and hold potential for the concept for care homes as community hubs. While current legislation forces services into silos, work to integrate services, particularly children's and adults care services should begin with the arrangements of shared sites. Co-locating nurseries within long term care facilities would sustain interactions, help build informal connections and encourage the use of shared resources. This also ties in with the united nations decade of healthy ageing and the Social Services and Wellbeing acts principles and recognition of the need to connect stakeholders through multiagency working to align and achieve their actions. The more stake holders are able to connect across disciplines, the greater the leverage of resources and shared goals. For policymakers this may offer an insight into how

their support and enablement of one social group will inevitably have knock-on effects for others, including practitioners.

The ability of IAP to enhance attitudes of younger people towards older adults, holds the potential for significant longer-term impact in determining future career choices of the future generation into social care, contributing to the strengthening the expansion of the social care workforce and counter current downward trends in recruitment into the sector. In order for this to happen, it is clear from this research that repeated interactions with older people needed to be sustained, otherwise lasting impacts on attitudinal change may be lost.

It is becoming increasingly important that future generations increase their knowledge and understanding around dementia as the population ages. This is something IAP and co-located nurseries and care homes may aid and promote. In relation to the age friendly domain of 'respect and social inclusion' IAP showed promise in its ability to readdress behavioural and psychological symptoms of dementia, and potentially generate greater social inclusion in care homes activities regardless of cognitive impairment. Whilst staff mentioned they had initial concerns over the somewhat unpredictable nature of some resident's behaviours prior to the start of the intergenerational programmes, interviews with care staff revealed that they observed less agitated behaviours exhibited by people with dementia during intergenerational activities. This reduction in agitation of care home residents was also found in a UK based evaluation of the 'Adopt a Care Home' scheme, where care staff reported that residents who normally display behaviours that challenge were engaged and remained seated (Di Bona et al., 2019).

On the other hand, in the active control group some staff felt it necessary to conduct separate activities with older adults who had more severe dementia, reported by care staff in the non-intergenerational setting. Instead of trying to understand the reasons for such expressive behaviours (e.g. banging the table during an activity may be because the person needs help or because they are frustrated at being unable to complete the task) some staff seemed to accept these are just part and parcel of the symptoms of dementia, As highlighted by previous research that suggested that the '*focus in many nursing facilities is on completion of daily tasks rather than treatment of agitation' (*Cohen-Mansfield, Marx, Dakheel-Ali, Regier, Thein & Freedman 2010, *p. 2*).

The potential contribution of IAP with regard to greater inclusion of people living with dementia in activities within care homes, also contributes to sustainable relationship-centred social care. For example, previous research which explored behaviours of dementia that challenge suggested that such behaviours respond to approaches that enable distraction, and that these may be prevented by 'altering interactions and the environment' (Brodaty et al, 2003, p. 232). This study found that the essence of intergenerational activities was in the interaction at that moment in time, with fully in the 'present moment' older adults forget their problems.. The interaction and relationships formed with younger people did indeed seem to act as a distraction, shifting focus away from success (or otherwise) at the task in hand. Other research had also noted that relationships from outside drew residents away from focus on ailments and anxieties (George & Singer, 2011). These 'in the moment' experiences were not described in relation to other non-intergenerational activities.

While mood seemed to be positive when engaging in activities generally across both settings, semi-structured interviews elicited conversations with older adults in the intergenerational setting that suggested one of the primary motivators to regularly attend was the sense of fun and life the younger people bought to the care home. This promotes a sense of positivity throughout the care homes, given the challenges the sector is facing in the wake of COVID-9 this is something is not to be underestimated. A study by Kolanowski et al. (2012) found that people living with dementia who were in a more positive mood demonstrated greater attention during activities and less disengagement. This might explain why some of the staff reported reduced number of challenging behaviours linked to dementia during the intergenerational activities and that perhaps intergenerational activities have that same therapeutic effect as other stimulating interventions (e.g. snoezel rooms and light activity) (Jakob & Collier, 2017). This research seems to suggest that the reduction in some of the usual agitated behaviour of some residents with dementia displayed in the IAP compared to the non-intergenerational activity programmes may be due to a greater level of one-to-one social interaction and engagement, a somewhat 'therapeutic' influence of younger people. The potential therapeutic effect of IAP warrants further research attention.

Aligned to principles of relationship centred care, a key aim of the social services and wellbeing act was to 'shift the focus of the workforce and indeed all practitioners and professionals engaged in social care from a task-based approach to a focus on well-being outcomes for people' (Verity et al., 2020, p.14). Research in care homes tending to focus on a 'medical

model' and physiological measurements or other medicalised indicators (degree of frailty, number of falls, and BMI rather than opportunities that bring meaning to residents. This is often reflected in the ethos of care staff who are under substantial pressure due to staff shortages and recruitment issues, many are more concerned about completing observations of residents (e.g. temperature and bowel movements) rather than engaging in meaningful activities. This reflects the pressures of task-oriented work schedules exercises and reporting taking precedence. IAP does hold promise in shining light on the ability to create spaces which allowed care staff to reflect and recognise the importance of social connections and 'what matters' to people who use services, carers, and communities. This creation of environments which dedicates and invests care staff time and resources into in establishing relationships, both with the person with dementia and other staff, contributing to creating a sense of security, especially for carers building upon the senses framework (Nolan et al., 2006). Findings from this thesis begin to explore the power to IAP to enable and enhance the senses set out by Nolan (2006) in the delivery of relationship centred care. Whilst the importance of relationships has emerged as a key theme, as well as enhanced feelings of satisfaction and purpose amongst activity co-ordinators, more focused research is needed to explore in more detail how IAP contributes to fulfilling the senses framework and subsequent delivery of relationship centred care.

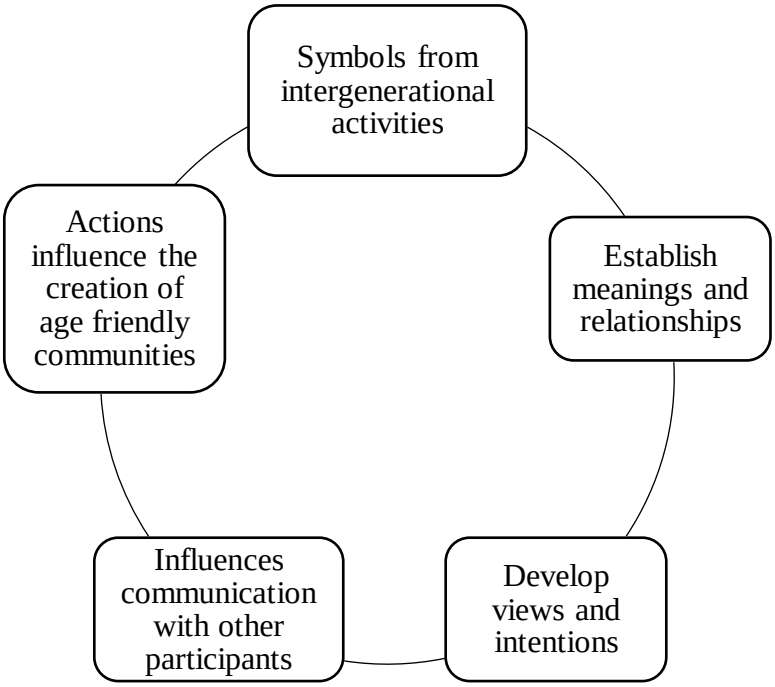
There is a risk and also a contradiction that intergenerational practice might be seen as a 'one size fits all' approach to tackling a range of complex and overlapping policy priorities. This could hinder the development of a specific mandated policy for intergenerational activities and presents a barriers for the development of these initiatives, potentially reducing them to an additional extra in much social care provision. This research calls for practitioners and policy makers to recognise the complexity of processes within an intergenerational activity programme and recommends a focus on relationships perspective intergenerational sheds light on and the need to adapt practice to suits the needs of those involved.

Many of the current policies in Wales and beyond, such as the Age friendly Wales strategy (Welsh Government, 2021), Social services Wellbeing Act (National Assembly for Wales, 2014), the UN decade of healthy ageing (United Nations, 2020) 'encourage' and support intergenerational activity. Yet these often fail to equip practitioners with the tools to translate this support into practice. This study is one of the first to have drawn on the links between intergenerational relationships and symbolic interactionism as a potential theory in explaining some of the process of behind intergenerational activities Figure . For example, participants

developing the meanings associated with objects linked to intergenerational activities, and how this impacts on subsequent intention of future actions, such as engagement, communication and maintenance of positive effects.

Figure 18

Symbolic interactionist perspective on intergenerational activities in care home

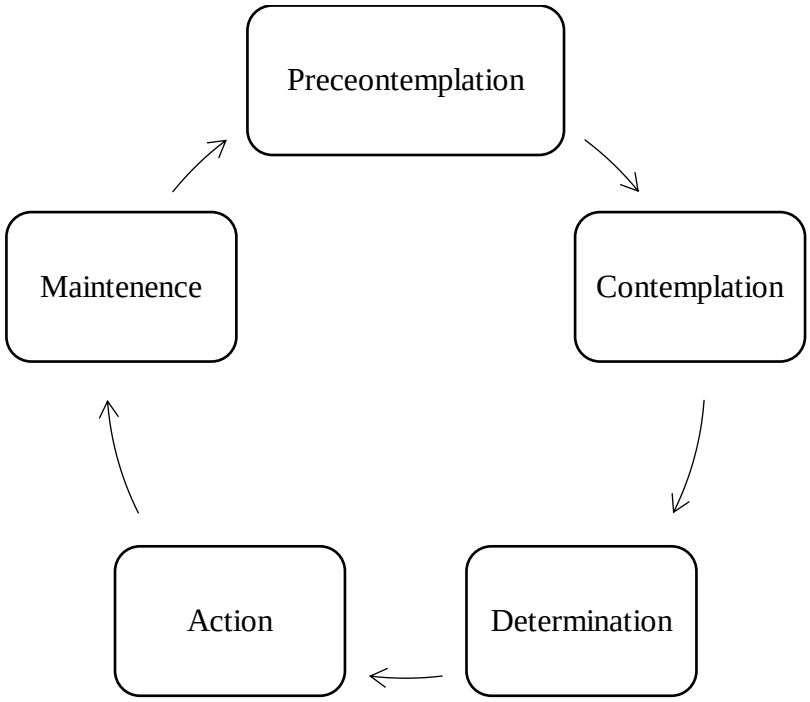


This study suggests that there are benefits accrued from intergenerational contact within intergenerational programmes in care homes. However, research and practice may benefit from also examining the reasons behind intention or lack of intention to engage with intergenerational activities. and behavioural change. As highlighted in the limitations, care staff in this study acted as gatekeepers, identifying individuals who they thought would be most likely to participate in activities. Therefore, their intention and subsequent action to engage was already anticipated. The study highlighted instances where some older adults, particularly males, were more resistant to engage in the activities. They tended to observe from a distance initially, contemplating engagement and eventually built up a receptivity to engage at a later stage. Intention and contemplation is an important variable in predicting behaviour change, suggesting that behaviours are often linked with individual attitudes and subjective norms (Godin, 1995) which has been particularly in the transtheoretical model (Figure). Future

research that considers intention to engage may elucidate how encouragement can be translated into engagement that is maintained over time. Thus, in the future research outputs may equip facilitators with the information, tools and techniques to engage those who are more hesitant to engage as demonstrated in this study.

Figure 19

The Transtheoretical Model (Stages of Change)



Although there is beginning to be a shift and greater appreciation of more dialogic and storytelling methodologies (Andrews & Beer, 2019), social outcomes such as connectedness, meaningful social interaction and sense of being cared about to others have are still often deemed as more abstract and 'soft' outcomes that are difficult to measure and capture (Granville, 2002), compared to quantitative outcomes when it comes to decision making with policies.

9.2. Strengths and limitations

This thesis set out with ambitious research questions, with just one researcher to complete the research. For this reason, findings covered a large breadth of areas, which would benefit from

further deeper dives into specific aspects through future work. The research was ambitious in its aims to capture a range of outcomes across three stakeholder groups as well as the underlying processes and content quality of each of the programmes included in the study. The various methods used to explore these each had limitations to the amount and quality of information they were able to elicit. For example, the older adults questionnaires could have been made shorter as they were quite long and tiring for the participants. While the questionnaires asked important questions they were not sensitive enough to fully capture the actual moments of intergenerational activity in the social care setting. Exploring the process of each of the intergenerational activity programmes through facilitator field notes that relied on facilitators to complete, was a limitation recognised within the research and the resources available. This required facilitators to firstly remember to complete the facilitator field notes and subsequently, provide as much detail on the content of the activities as possible in the absence of the researcher. Despite the researcher providing guidance, prompts and reminders to the facilitator to complete the field notes, the extent to which facilitators completed these varied with some facilitators providing much greater level of detail than others. Thus the reporting of the content and quality of the activities was not as detailed as the researcher would have hoped.

While some influencing themes and factors relating to the quality of the activities emerged from the data, such as good communication and care homes that had bigger lifestyle teams (page 174) were better resourced to provide the activities, the researcher did not have influence or control over the delivery or content of the programmes. The researcher tried to remain as reflexive as possible and aimed to have as little influence over the quality and content of the activities. In order to do full justice to the research questions, a dedicated researcher for each programme would have been beneficial, enabling the researchers to have time to build trust and relationships with those involved in the activity programmes and ensuring greater consistency of data collection across all settings.

Another problem with this approach was that facilitators notes were susceptible to social desirability and open to biased response. Whilst the facilitator feedback notes provided insight to experiences, enablers, and barriers along with qualitative interviews, more robust observational data would have helped to support and build upon the findings presented in this thesis. This would also help further develop the understanding and contextual influences behind IAP implementation and delivery (Jarrott et al 2019). This would also help capture the impact

of the broader ethos of the care home, for example, the value placed on activities and prioritisation of them by care staff when constrained by time and resources. This is something that was touched upon by this study in relation to 'buy in' from management, but could be explored further, especially considering the pressures of COVID 19 and state of austerity within the care sector.

While some aspects of the research were standardised (e.g. the minimum requirement of the number of sessions delivered), other aspects (e.g. the environmental component, delivery, content) were specific to each care home involved. There was a vast number of factors relating to the context that were not captured which could also have impacted on the results of this study. For example, care home capacity, care home ethos, the care homes that had capacity to run intergenerational activities in the first place, may potentially impact upon the comparison of outcomes between settings, in terms of their resources and subsequent ability to deliver activities. As a result, this study grappled with capturing the contexts within which each intergenerational and non-intergenerational activities were carried out.

To ensure a more realistic representation of intergenerational activity programmes that occur in care homes, the content of the activities used within this study were not standardised. The active control settings encompassed a range of activities from bingo to singers, within the intergenerational settings. While the activities were based around intergenerational interactions, the activities carried out also varied between settings. This study highlighted that intergenerational components are more effective than those without an intergenerational component. Further research could focus on whether there are some particular activities that are more effective than others. For example, comparing an activity that doesn't have an intergenerational component and to another one that does across settings could increase the standardisation of activities.

However, it is important to point out that whilst such an approach may enhance the standardisation of the research, the findings from this study suggest that intergenerational activities need to be flexible and responsive to the needs of those involved. This essential component of IAP may be limited by such standardisation and constraints over the flexibility and content of programmes and require different iterative approaches and action research methods.

In terms of looking at an all Wales context, this research focused solely on South Wales, with all care homes included in this study located in the south Wales region of the UK. This is more populated and urban than other areas of Wales such as North, mid and west Wales. For example, the majority of the care homes were in walking distance or a short drive from the schools, as a result transportation was less of an issue when compared to intergenerational projects in more rural settings in Wales, with travel and travel costs potentially raising greater barriers. Another factor that might differ between North and South regions of Wales is the impact of the use of Welsh language. Two Welsh speaking schools were included. In one care home Welsh-speaking was initiated by the children rather than the residents. This benefited particular residents providing them with opportunities to speak Welsh to the children. The care staff in that care home highlighted this as an additional benefit to that resident as there was not many Welsh speaking care staff in that care home at the time. This was just one CH in this study but this might be different across Wales, specifically more West and North Wales, where Welsh language is much more prolific. Intergenerational activities might have even more of an impact in terms of facilitating and spreading Welsh language to the younger communities. It could provide an important vehicle to enhance the learning from older people to the younger people in terms of Welsh language, community and wider culture.

In addition to this the gender of the study sample was particular skewed with far more females than males, with the majority of older adults study sample were caucasian females. As a result evidence was not captured from individuals from different cultural and ethical background. These results must be used with caution in terms of generalizability to other ethnic groups. Further to this, this imbalance amongst the older adults included in this study might have impacted the dynamics of relationship-based activities and intention to engage with gender potentially being a relevant factor in how the older adults engaged with the younger people. Therefore generalisability of these findings within Wales should be used with caution. Future intergenerational research conducted in Wales should aim to achieve a representative spread of participants, in relation to gender of older participants and from across all regions of Wales, including both rural and urban settings. Particular attention should also be given to the difference in intention to engage and the dynamic of the relationship-based activities between male and female older adults.

While this study provides a framework of the findings in this study (Figure 17), intergenerational activities and the impact they have on individuals will inevitably vary, in line

with symbolic interactionism that intergenerational relationships are open to interpretation and individuals own assignment of meaning and intentions, thus outcomes are not limited to just these captured in this study. This reflects a limitation of this study in that gatekeepers selected those that were most likely to want to engage with such activities, which may account for the lack of negative comment regarding the IAP. Importantly, this study did not capture the views of those that did not want to take part in IAP. Recognising the reasons why people do not want to take part in the intervention and including those that chose not to take part in the IAP also holds great value for future research. For example, some individuals might not enjoy, or anticipate they may not enjoy the company of children, and would not want this 'intervention' inflicted upon them. To understand who intergenerational activities work for, researchers need to try and understand who it may or may not work for. Further exploration of the reasons for non-participation or reasons for drop out of an intergenerational activity may shed a different light when thinking about whether an intervention would work and who it would work for and tailoring intergenerational and non-intergenerational activities in care homes.

Reasons for non-participation, is also aligned to the selection and recruitment processes used by care staff. As the researcher was not directly responsible for the recruitment of specific people to the activities, the study was unable to control for how individuals were informed, encouraged or otherwise or had equal access to these types of activities. Recruitment processes might potentially exclude some individuals particularly those with more severe forms of dementia. Similarly, many of the individuals interviewed were ones that care staff had preconceived opinions on whether they would engage or enjoy intergenerational activities. It is important to consider that staff may be more likely to put forward their 'best performers' in order to answer questions or provide responses in relation to their experiences of the activities. Whilst this study did include people living with dementia, those with more severe dementia who were unable to provide informed consent were excluded. Future research should consider how to ensure individuals with more severe dementia have access to intergenerational activities and opportunities to part take in research to determine the potential (dis)benefits (Baker et al., 2017).

10. Chapter Ten - Conclusions and recommendations

10.1 Conclusions

Intergenerational activity programmes have been associated with an array of different impact and outcomes. However, to date, intergenerational practice has often been driven by values, and not by clear and robust evidence. As a result, policy recommendations have lacked supporting evidence, and have been unable to unpack the mechanism of change and the processes by which these positive outcomes can be achieved. A large body of research has explored the impact of community based IAP, but IAP in care home settings has rarely been explored (Jarrott et al 2020). This thesis explored different IAP across a range of care settings in South Wales. It offers a reflexive account of IAP in action: where by processes and individual quantitative and qualitative outcomes were captured, and triangulated.

In line with the three key research questions this thesis set out to address, the study found the following key findings.

In relation to RQ1 the study demonstrated that:

- Older adults involved in the intergenerational programmes demonstrated a significant improvement in quality of life and engagement in meaningful activity compared to those that were involved in non-intergenerational activity programmes.
- Younger people demonstrated a significant improvement in their attitudes towards older adults having taken part in the intergenerational activity programme. However positive attitudinal scores started to dip at the 3 month follow up.
- Whilst staff were highly positive about the experiences in intergenerational settings, the study found no significant changes in job satisfaction over time between in either setting.

In relation to RQ2 the study demonstrated that:

- Intergenerational activities helped create a space for one to one interaction and establishing meaningful relationships between staff, residents and younger people.
- The development of meaningful relationships and friendships between older and younger participants was the key driver for the success of intergenerational activities, through the exchange of symbolic gestures and objects

- The type of activity carried out did not affect outcomes. Instead objects associated with the activities or made during the activities acted as the catalyst for conversation. Participants revealed things they may not have found in common without a tool to aid communication.
- Taking a tailored and flexible approach to IAP, which can be adapted to fit the needs of different settings and circumstances is key. Having broad themes, rather than specific set activities allowed the development of meaningful interactions.

In relation to RQ3 the study demonstrated that:

- IAP in care homes help encourage and create spaces which foster three of the eight domains in the WHO age friendly environment model (i) social participation (ii) respect and social inclusion and (iii) communication and information.
- IAP help create environments which dedicated and invested care staff time and resources into in establishing relationships, both with the person with dementia and other staff. Building upon the senses framework, this contributed to creating a sense of continuity, achievement and significance.

By exploring the mechanisms of impact, it was intended that this study could shed light on sustainable practices and contribute to the development of evidence based practices within intergenerational contexts (Stame, 2010). This is a goal supported by the Welsh Government's Social Services and Well-being Act (2014) and the Age Friendly Wales Strategy which emphasises the importance of *'encouraging intergenerational contact'* (Welsh Government, 2021 p.40).

In line with the concept of age friendly communities, this study has demonstrated that intergenerational activities encourage and enable positive social participation and interactions in care home environments. In turn, this helped to challenge stigma around dementia and care homes generally. Care home can often be seen as places of ill health and loss of independence, and having the children present can refocus the sense of meaning in life, shifting attention towards the celebration of the life course, and heighten sensitivity and awareness to some of the basic and more meaningful exchanges in life, rather than a focus on the end of life.

Rather than being a short term passing media interest , *'Ad hoc'* and a *'Nice thing to do'*, this study adds to the growing evidence that intergenerational activities bring added value to all stakeholders involved. Formalising links between organisations and ensuring the regularity of delivering such activities is key in harnessing the full potential and benefits and enhancing sustainability over time. Intergenerational activities provided the opportunity to form new relationships and experiences for older and younger people, and for staff to perceive residents in a new light. There was a shift away from the focus on the activity itself, to the activity being the catalyst for conversations and the formation of meaningful relationships.

This thesis highlights a relatively new theoretical perspective when looking at intergenerational activities, that is, symbolic interactionism. It has outlined the foundations for a potential theoretical premise for explaining processes behind intergenerational activities; detailing ways in which outcomes linked to intergenerational activities are sustained or not sustained through symbolic interactionism. This is in contrast to the approach most frequently drawn upon by intergenerational researchers, that is contact theory, which often neglects context and processes of change. Intergenerational activity programmes created environments that fostered the creation of friendships and meaningful relationships between older and younger participants in communities where social norms often prevent such opportunities. The study demonstrated how quickly intergenerational friendships can develop in environments which foster inclusion. Findings from this study indicate that relationships and social interaction, especially those between different generations play an important role in the engagement in meaningful activities and subsequent self-reported quality of life for older adults living in care homes across South Wales. These feelings of enhanced quality of life were sustained by the creation of symbols to which older adults associated positive meaning. The importance of repeated interactions was highlighted as there was a decrease in attitudinal scores of younger people towards older adults following the cessation of the project. Sustained benefit may be accrued if younger individuals also created objects that they were able to take away. Crucially, this research has highlighted the relationality between practitioners, participants, objects, and care home and national policies in the delivery of intergenerational practice within social care. Ensuring the views and influence of staff, activity coordinators, symbolic objects and the environments are collectively taken into account is key for future research and practice.

The results demonstrated that there were tensions in policy recommendations concerning the value of IAP and stretched resources within care settings. The ability to combine resources

from the care home and schools, demonstrated that intergenerational activities offered a way of keeping pace with social care policies with relatively few resources. This research found the perceptions of costs associated with the activities emerged as a theme, however no formal cost evaluation was carried out. Although, there is the need for future research in Wales in explore this comparing more rural locations across Wales where the proximity of care homes and schools may vary considerably meaning transport costs may impact on this. These is also a need for additional support from policy makers in both advocating for intergenerational activity programmes through intergenerational co-ordinators network within local authorities, but also to empower, enable and sustain such practices with adequate tools and funding, going beyond 'encouraging' and exploring reasons behind intensions to interact or not .

Care homes contexts comprise resources, buy-in from management and staff, care culture, values and beliefs, and are influenced by national policies and legislation. The way in which intergenerational activity programmes play out is, therefore, dependent not only on the individual participants involved, but also a range of complex interacting factors around and between them. This research recognises that striking the right balance between replicability and a tailored approach is difficult. Future research could explore how we can create a model of IAP that is flexible enough to be of local and personal relevance to those involved, but is also standardised enough to enable consistent implementation and intergenerational practice that is of sound quality in care homes across the UK. In order to be manageable and easier to understand the components and complexity of IAP is often simplified, and focused on utility. This study suggests that practice in context (taking research evidence but adapting it to suit the needs of those involved and develop it via forms of community of inquiry approaches) should be adopted in future intergenerational approaches. As with replicability, there seems to be a fine balance between recognising the power of IAP but resisting the urge to overestimate its value. Wright-Bevans (2017) suggests that IAP is more than *'simply as a tool for changing attitudes*'. Weighing up the evidence from this study, the research suggests that while IAP may not achieve large scale societal change, it can positively contribute to the shift towards for relationship-centred approaches to care.

Aligning with results from other studies (Clarke et al., 2019; Gigliotti et al., 2005), intergenerational activities were viewed as separate to the care provided to residents, and therefore, considered less significant when staff capacity was limited. However, this research

suggests that intergenerational practice holds promise for creating spaces where care staff were permitted to reflect and recognise the importance of social connections to residents, carers and in the creation of age friend care home communities.

10.2 Recommendations for IAP in care homes within the UK

There are six main recommendation for IAP in care homes in the UK that can be drawn from this study that are detailed below. These reflect the need for action from both practitioners and academics, and most critically Welsh government. Firstly, the research demonstrated the need to shift narrative of intergenerational practice away from something that's 'nice to have' rather than a nuanced and complex practice interacting with social care sustainability. Whilst the study had limitations, as outlined above, the feedback and findings in relation to the impact Intergenerational activities had on all those involved was generally positive.

One recommendation the Welsh Government could take forward is funding for a designated local authority community intergenerational co-ordinators. This has been set up in one council in North Wales, but extra funding is needed for this role to roled out across the 22 local authorities in Wales. The intergenerational programmes in this research had these roles informally but the informal nature of this role was reflected in the quality and delivery of the activities, with breakdowns in communication between the schools and care homes occurring often. These co-ordinators could be responsible for developing connections between schools and care homes in their local area, to provide a vital link between education and care providers in each locality. This could include creating a 'twinning' system between local schools and care homes. This would replicate the informal grass root co-ordinators which is nurtured by passionate individuals or supportive organisations, creating a bottom up approach to intergenerational work within care homes. This would also build on the Welsh Governments Age Friendly Strategy's recognition of encouraging intergenerational contact, proving greater strategic and practical commitment (e.g. funding) to intergenerational practice at practice and workforce levels.

In order to support this bottom up approach and ensure maximum impact of these community coordinators, a more top down approach of establishing a national centre for international practice in Wales would be advantageous. This could help support the co-ordination of this network, and support care homes to carry out intergenerational programmes more sustainably

and share and disseminate best intergenerational practice, tools and resources relevant to the Welsh context. While a Cymru Centre for Intergenerational practice had been established previously from 2004 to 2007, Welsh specific research evidence around Intergenerational practice was limited. The growing momentum of IG practice, this research and other intergenerational researchers in Wales, as well as the formation of a cross party group on intergenerational solidarity in Wales creates a strong case to Welsh government to reinstate this centre within Wales once more.

IAP provide opportunities for shared resources and sustained interactions within care homes and hold potential for the concept for care homes as community hubs. Whilst current legislation forces services into silos, work to integrate services particular children's and adults care services should begin with the arrangements of shared sites. Co-locating nurseries within long term care facilitate would sustain interactions, help build informal connections and encourage the use of shared resources, something that this research showed promise with through visitation type intergenerational activity programmes. Again, aligning with the Social Services and Wellbeing Act that encourages the implementation of programmes that can be carried out in various contexts.

The emergent theoretical position of symbolic interactionism drawn from the findings of this study shone a light on the importance of symbolic gestures in the processes of meaning-modifying interactions between participants, including their self-interaction and how participants interpreted these objects' symbolic meaning throughout the course of the activity programme and beyond. Further work by intergenerational researchers is needed to explore this emergent theory further and the role symbolic interactionism might have in altering meaning and intentions of participants to be involved in intergenerational activities. Particularly the intention for male participants to engage or contemplate engaging in intergenerational activities, as this study highlighted the intention of females to engage in such activities was much greater and males tended to watch from the outskirts and gradually start to participate as the weeks went on. The research also recommends that facilitators of the Intergenerational activity programmes in care homes should encourage the creation of symbolic objects which participants can take away with them to keep as a reminder of the activities. This research suggests that this may help sustain the beneficial impact of the activities when the participants are not physically together. This process and the association of

meaning to interactions and objects is something that needs to be further explored by future research.

This study is one of the first to look at the impact that IAP has on care staff. There is still work needed to be done in relation to staff capacity, care staff perceptions of their responsibility to engage residents in meaningful activities, should be enhanced. There is a need for future practice of intergenerational activities in care homes to enhance manager and care staff buy-in to IAP by including benefits of intergenerational activities in existing training. Staff training can help facilitate the provision of greater meaningful activity by highlighting and reinforcing the importance of providing opportunities for residents to engage in meaningful activities that are central to upholding the dignity of residents, and securing their human rights (Welsh Government, 2014). Training should also support and enable care staff create environments for the development of intergenerational relationships, encouraging residents' desires and needs for meaningful social interactions and engagement within care homes. IAP offer activity co-ordinators a way to highlight the importance of relationships and the work they are doing on a day to day basis, instilling a sense of purpose and achievement to their role. Whilst this was not demonstrated through quantitative outcomes such as job satisfaction (possibly because a range of care staff were included), findings from this thesis begin to explore the power to IAP to enable and enhance the senses set out by Nolan (2006) in the delivery of relationship-centred care. With the importance of relationships is highlighted in social care research, further research is needed to explore the contribution IAP can make to delivering the senses framework.

Care staff training should also describe mechanisms of delivery, highlighting issues around implementation. Given the inevitable challenges of implementing and developing intergenerational practice in the current social care context, there needs to be greater acknowledgement that, just as activities, staff and the environment can constrain as well as enable positive relations. Successful intergenerational work will inevitably encounter failures. IAP is not a one size fits all, and activities might not be perfect first time round. Sustainability is about adapting to these conditions and circumstances of success/failure to shape the activities to suit the personalities of those involved. Adaptability, as a feature of sustainable intergenerational policy and practice, may be informed by a greater appreciation of the relational and symbolic elements to the activities. Future practice should aim to find a balance between structure and allowing for more informal, organic interaction of activities to come about. A good example of adaptability was where one activity facilitator explained how

structured activities turned more into themes of the sessions as each week progressed. The intergenerational programmes included in this study varied in terms of the programme design, some opting for a more structured, explicit approach where all objectives and participants are clearly defined before the start, and those set up with an emergent approach, where the activities and facilitation strategies may evolve with the programme (Kaplan & Larkin, 2003). Intergenerational activities that found a balance between structure and allowing for more informal flexible, and organic interaction of activities to come about enabled the development of relationships to take precedence rather than the activity. For example, using themes for the sessions instead of structured activities. This variability and need to find an approach that suits all those involved is an important to highlight for researchers, practitioners and policymakers. If we want approaches to studying, running and promoting these programmes to be realistic and meaningful for the setting, they are likely to require local adaptations and responsiveness to a variety of factors including staffing, priorities, funding, and spaces. This, however, does not remove the need for national support and infrastructure.

Improvement and development teams associated with the social care workforce such as Social Care Wales and CIW, might also play a pivotal role in mobilising the knowledge. These organisations possess the capacity to share and disseminate good practice and research findings that are linked to key government strategies such as the Social Services and Wellbeing act, the Age Friendly strategy and the Wellbeing of Future Generations Act. This is something that should be considered by intergenerational researchers as a form of disseminating findings and sharing intergenerational research, bridging the gap between, research, practice and policy. This need for multi-organisational efforts to share knowledge and engage individuals to create environments that are fit for all ages is key if we are to achieve the outcomes outlined in the decade of healthy ageing.

The study highlights the need of deeper understanding of interventions and process between participants relationships. Exploring participants own agenda and meaning for engagement and how this changes throughout the course of an intergenerational activity programme. The use of more creative and dialogic methodologies such as storytelling and social pedagogy would optimise opportunities for learning and development (Andrews, Gabbay, Le May, Miller, O'Neill & Petch, 2015) and how to support children and adults who may find it more difficult to engage.

A more relational perspective towards intergenerational research, policy and practice would also create opportunities for those from seemingly disparate fields, such as early education and social care, to notice the potential of intergenerational practice to accommodate shared interests and resources, reasons for collaboration and, in some cases, mutual investment. The true potential of intergenerational practice may be realised when it is viewed not only as a project that works with the young and older of society but a matter of bringing individuals of all ages together for the benefits of all involved. At the same time, the reader should acknowldge the limitations and boundaries of this relatively short-term study with a female dominated sample of older adults. Therefore caution should be taken in generalising the findings. While, this research has demonstrated a number of benefits associated with the delivery of intergenerational activities in care homes, it has also highlighted the strain social care providers are often under. This was emphasized by the recent COVID-19 pandemic which shone a light on the power that social connections (or lack of it) can have on care homes and their communities. Reconnecting meaningfully with care homes and its residents is more important than ever.

Finally, drawing attention to the crucial, but often under-acknowledged, role of practitioners and nonhuman factors such as objects, care home policies, and caring practices demonstrated that a non-reductionist approach may explore the multi-dimensional nature of intergenerational interaction. Reducing intergenerational practice to an 'add on' to good social care provision is not enough and may be countered by formalised intergenerational policy or care home practices which provide infrastructure and support for fostering meaningful relationships. Although there is no policy solution to these challenges, these findings do fuel aspirations for a policy, practice and research landscape which can embrace the complexity of intergenerational relationships as part of a sustainable approach to intergenerational practice within social care.

10.3 Final reflections – A note from the researcher.

I set out with a pragmatic point of view, given limited resources and time, and a focus on understanding specific quantitative outcomes associated with a range of stakeholders involved in IAP run in care homes. I quickly realised that to make sense of IP in terms of purely quantitative outcome neglected key influencing factors and was too deterministic. Understanding if and how IAP achieves change also meant diving deeper and exploring

individual experiences and processes. The realisation of a formalised structured intervention was influenced by the highly contextualised nature of care homes, and the roles of different individuals within them. While the idealist in me would like to relay IAP as a simple tool, I end this research project with a deeper understanding of the complex nature of care homes, the underlying influence management has on the care homes culture and capacity to deliver a meaningful activity programme. However, I do come away from this work with a sense of realistic optimism having experienced the power of small scale IP as an approach to promote meaningful relationships and sense of community within care homes across south Wales. Something that I will continue to advocate in my future endeavours.

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Appendix

Contents:

Appendix 1 – Copy of NHS ethics approval letter

Social Care REC
Ground Floor
Skipton House
80 London Road
London
SE1 6LH

Telephone: 0207 972 2568
Fax:

04 January 2019

Professor Vanessa Burholt
[redacted]

Dear Professor Burholt

Study title: **Evaluation of the impact of intergenerational activities on relationship-centred care and care outcomes in care homes**

REC reference:
Protocol number:
IRAS project ID: [redacted]

Thank you for your letter of 02 January 2019, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of advertisement materials for research participants	10	29 October 2018
Covering letter on headed paper [Covering Letter]	2	02 January 2019
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)	1	16 October 2018
Interview schedules or topic guides for participants	10	29 October 2018
IRAS Checklist XML [Checklist_03012019]		03 January 2019
Letter from funder	1	01 January 2018
Letter from sponsor		16 October 2018
Letters of invitation to participant	10	29 October 2018
Other [Research Assistant advertisement letter]	10	13 November 2018
Other [Disclosure of Harm Process]	3	02 January 2019
Participant consent form [Participant consent form]	10	29 October 2018
Participant consent form [Participant consent form]	10	29 October 2018
Participant consent form [Participant consent form]	10	29 October 2018
Participant consent form [Participant consent form]	10	29 October 2018
Participant information sheet (PIS) [5 to11 year olds]	11	21 December 2018
Participant information sheet (PIS) [11 to 18 year olds]	11	21 December 2018
Participant information sheet (PIS) [Family/friends (Quantitative)]	11	21 December 2018
Participant information sheet (PIS) [Older Adults (Screening Questionnaire)]	11	21 December 2018
Participant information sheet (PIS) [Parents of Younger People]	11	21 December 2018
Participant information sheet (PIS) [Staff (Quantitative)]	11	21 December 2018
Participant information sheet (PIS) [Participant Debrief Form]	11	21 December 2018
REC Application Form [REC_Form_07112018]		07 November 2018
Referee's report or other scientific critique report		19 June 2018
Research protocol or project proposal	5	13 November 2018
Summary CV for Chief Investigator (CI)		29 September 2018
Summary CV for student		29 October 2018
Summary CV for supervisor (student research)		29 September 2018
Summary, synopsis or diagram (flowchart) of protocol in non technical language	10	29 October 2018
Validated questionnaire [Care Staff Questionnaire (T1)]	11	05 November 2018
Validated questionnaire [Care Staff questionnaire (T2 and T3)]	11	05 November 2018
Validated questionnaire [Family and Friends Questionnaire (T1)]	10	29 October 2018
Validated questionnaire [Family and Friends Questionnaire (T2 and T3)]	10	29 October 2018
Validated questionnaire [Older Adults Screening Questionnaire]	10	29 October 2018
Validated questionnaire [Older adults Questionnaire and manual (T1)]	10	29 October 2018
Validated questionnaire [Older adults Questionnaire and manual (T2	10	29 October 2018

and T3)]		
Validated questionnaire [Younger persons Questionnaire (T1)]	10	29 October 2018
Validated questionnaire [Younger persons Questionnaire (T2 and T3)]	10	29 October 2018

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at
http://www.hra.nhs.uk/hra-training/

18/IEC08/0043	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

[redacted]

Pp Dr Martin Stevens
Chair

Email:nrescommittee.social-care@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Dr Sherrill Snelgrove*

Appendix 2 – Participant and care home information forms

Participant Information Form - Parents of Younger People

Exploring the impact of activities and relationships on all stakeholders residing, working and visiting Residential and Nursing Care homes across South Wales

We would like to invite your child to take part in a research study, and would like to seek your consent to do so. Before you whether to consent that your child participate or not, it is important for you to understand why the research is being carried out and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand.

We would also encourage you to discuss this invitation with your child and other professionals involved in the provision of delivering the activities within residential care home. We would like to stress you do not have to accept this invitation and should only consent for your child to take part if you are happy with this. Where we have your consent, we will then ask your child if they would like to take part in the study.

Thank you for taking the time to read this.

1. What is the purpose of the study?

Care homes often provide activities for residents. We are interested in the impact different activity programs run in care homes across South Wales have on the care home residents, staff, kin/non-kin caregivers, and younger people.

2. Why has your child been chosen to take part?

Your child has been involved in a project which run structured activities programme in a care home with older adults. We would like to invite your child to provide us insight into their experiences of the activities programme they have been involved in.

3. Do I have to consent for my child to take part?

They do not have to take part in this research. Participation is voluntary and participants are free to withdraw at any time without explanation and without it affecting your child's participation in the activities program.

4. What will happen if my child takes part?

We would like to invite your child to take part in our research which will involve a short face to face interview about their experiences and views on taking part in the activities with the older adults. The researcher will ask questions relating to your child's experience of the activities programme. The interview is likely to take around 20 minutes and will be conducted within the grounds of your child's school.

5. Who is carrying out the research?

The data are being collected by PhD researcher Kate Howson, from the Centre for Innovative Ageing located within College of Human and Health Sciences. The research has been approved by the College of Human and Health Sciences Research Ethics Committee.

6. Expenses and/or Payments

There are no expenses or payment being made to participants.

7. Are there any risks in taking part?

There are no risks involved in taking part. However if your child does not want to answer any of the questions they do not have to – they can simply tell the researcher they want to stop. Your child will be asked about contact with their grandparents, if you thinks this might be upsetting for your child (e.g. bereavement, family breakdown), you should consider the decision of your child's participation carefully. We can stop at any time, and ask your child if he or she would like to resume at a later time or date, or withdraw from the study.

8. Are there any benefits in taking part?

There are no direct benefits for the individuals who take part in the study. We do however hope that the results will improve the delivery of activities in care homes and identify the most effective ways of improving the quality of life and wellbeing of all those involved.

9. Will my child's participation be kept confidential?

All information that is collected about your child for the study will be kept strictly confidential. We will not include his or her name or any other information that might identify them in the written record.

10. Will my child's taking part be covered by an insurance scheme?

Participants taking part in this ethically approved study will have insurance cover provided by Swansea University.

11. What will happen to the results of the study and how long will my data be stored?

Anonymised data will be stored on a computer for researchers to analyse during the course of the 3-year project. We are likely to present the findings at conferences, on our website and in journal articles. We will not use your child's name or any other information that might identify them in the research. Finally, data will be shared on UK Data archive in order to share the findings of the research.

12. What will happen if I stop taking part or if my child no longer wants to take part?

You and your child can withdraw from the study at any time without explanation. This decision to stop taking part in the research will not affect participation in any of the activities run in the care home. Results up to the time of withdrawal may still be used, if you/your child are happy for this to be done. Otherwise, you/your child may request that they are destroyed and no further use is made of them, this request must be made by 1st November 2019, before data analysis has commenced. However, data already collected whilst capable of consent will be retained and used in the study anomalously.

Data Protection Privacy Notice

The data controller for this project will be Swansea University. The University Data Protection Officer provides oversight of university activities involving the processing of personal data, and can be contacted at the Vice Chancellors Office: dataprotection@swansea.ac.uk.

Your child's personal data will be processed for the purposes outlined in this information sheet. Standard ethical procedures will involve you providing your consent to participate in this study by completing the consent form that has been provided to you and your child.

The legal basis that we will rely on to process your child's personal data will be processing is necessary for the performance of a task carried out in the public interest. This public interest justification is approved by the College of Human and Health Sciences Research Ethics Committee, Swansea University.

13. What are your child's rights?

You and your child have a right to access your personal information, to object to the processing of their personal information, to rectify, to erase, to restrict and to port their personal information. Please visit the University Data Protection webpages for further information in relation to your rights. Any requests or objections should be made in writing to the University Data Protection Officer:

University Compliance Officer (FOI/DP)
Vice-Chancellor's Office
Swansea University
Singleton Park
Swansea
SA2 8PP
Email: dataprotection@swansea.ac.uk

14. Who can I contact if I have further questions?

The person in overall charge of this project is Kate Howson. You can call, email or write to Kate with your questions or concerns using our contact details listed overleaf. Please ask questions as often as you want. You can contact her by phone or email on Monday to Friday between 9 a.m. and 5 p.m.

15. Who can I contact if I have a complaint?

If you would like to make a complaint or have there is a problem, please contact Professor Vanessa Burholt (Kate's supervisor). If you remain unhappy, concerned or have a complaint, with which you feel you cannot contact the supervisor, please contact the Head of Research in the College of Human and Health Sciences, Professor Mark Blagrove (details below). Please provide the name or a description of

the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.The complaint will then be promptly and impartially investigated, during which time you will be kept fully informed and remain in contact with the investigator.

CONTACT DETAILS :

Lead researcher: Kate Howson

Ageing and Gerontology Studies PhD Student

College of Human and Health Sciences

Centre for Innovative Ageing

Haldane Building

Swansea University

Swansea

SA2 8PP

Tel: [redacted]

Email: [redacted]

Research Student Supervisor: Professor Vanessa Burholt

College of Human and Health Sciences

Centre for Innovative Ageing

Haldane Building

Swansea University

Swansea

SA2 8PP

Telephone: (01792) 602186

Email: v.burholt@swansea.ac.uk

Head of Department – College of Human Health Science: Professor Mark Blagrove

College of Human and Health Sciences

Centre for Innovative Ageing

Haldane Building

Swansea University

Swansea

SA2 8PP

Telephone: (01792) 295586

Email: m.t.blagrove@swansea.ac.uk

Participant Information Form - Younger People

Exploring the impact of activities and relationships on all stakeholders living, working and visiting Residential and Nursing Care homes across South Wales

- You are being invited to take part in a research study.
- This information sheet will provide details about what to expect from the study, please read it before you make any decisions.
- You do NOT have to accept this invitation
- Feel free to ask us if you would like more information or if there is anything that you do not understand.

We would also encourage you to discuss this invitation with your parents /guardians and teachers involved in the delivery of the activities within residential care home.

Thank you for taking the time to read this

1. What is the purpose of the study?

We are interested in the impact different activity programs run in care homes across South Wales have on the care home residents, staff, kin/non kin caregivers, and younger people like you.

2. Why have I been chosen to take part?

You have are involved in a project that is running activities with older adults. We would like to invite you to be involved in a short interview which will ask you some questions about your experiences of taking part in activities with the older adults.

3. Do I have to take part?

You do not have to take part in this research. Not taking part in the research will not affect you doing the activities with the older adults.

4. What will happen if I take part?

We would like to invite you to take part in our research which will involve the researchers asking you questions about older people and the activities and should take around 20 minutes. We would like to do this once before the start of the activities programme and one after the end of the activity programme.

5. Who is carrying out the research?

The data are being collected by PhD researcher Kate Howson, from Swansea University. The research has been approved by the College of Human and Health Sciences Research Ethics Committee.

6. Are there any risks in taking part?

There are no risks involved in taking part. In the unlikely event that you become distressed or if you do not want to answer any of the questions you do not have to.

7. Are there any benefits in taking part?

There are no direct benefits for you by taking part in the study. We do however hope you enjoy being involved in the research and that we can see whether activities like this should be run in more care homes across Wales.

8. Will my participation be kept private?

Yes. No one else will know because we will not use your name or address. You will get a number which will be used instead.

9. What will happen to the results of the study and how long will my data be stored?

Swansea University is the sponsor for this study. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information

and using it properly. Swansea University will keep information about you 6 months after the study until June 2021. This private data will be stored on a computer for researchers to look at during the course of the 3-year project. We are likely to present the findings at conferences, and other educational platforms. We will not use your name or any other information that might identify you or where you work in the research.

10. What are your rights?

You have a right to access your personal information, to object to the processing of your personal information, to change, to erase, to restrict and to port your personal information. Please visit the University Data Protection webpages for further information in relation to

your rights. Any requests or objections should be made in writing to the University Data Protection Officer:

University Compliance Officer (FOI/DP)

Vice-Chancellor's Office

Singleton Park,

Swansea University

Swansea,

SA2 8PP Email: dataprotection@swansea.ac.uk

11. Who can I contact if I have further questions or a complaint?

Tell us if there is a problem and we will try and sort it out straight away, or alternative speak to Kate Howson the lead researcher (Contact details below). If you want to complain you or your mum, dad or carer can talk to Professor Vanessa burholt or Professor Mark Blagrove.

Contact Details:

Researcher: Kate Howson

Telephone: [redacted] Email: [redacted]

Research Student Supervisor: Professor Vanessa Burholt

Telephone: (01792) 602186 Email: v.burholt@swansea.ac.uk

Head of Department – College of Human Health Science: Professor Mark Blagrove

Telephone: (01792) 295586 Email: m.t.blagrove@swansea.ac.uk

Address:

College of Human and Health Sciences

Centre for Innovative Ageing

Haldane Building

Swansea University

Swansea

SA2 8PP

College of Human and Health Sciences
Coleg y Gwyddorau Dynol ac Iechyd

Swansea University
Prifysgol Abertawe

Exploring the impact of intergenerational activities and relationships on all stakeholders residing, working and visiting residential and nursing care homes across South Wales

Swansea University has an exciting opportunity for your care home to be involved in research!

Might YOU be interested?

What are we looking for from the Care Home?

This research aims to explore the impact of activities have on those working, residing and visiting Care Homes across South Wales.

Is your Care Home eligible to take part?

The activity programs must actively involve resident's age ≥ 65 years in residential or Nursing Care homes at least once a week for 8 weeks.

What will the research involve?

The research will involve the completion of questionnaires, surveys and interviews, which will be conducted by the researcher within the care home facilities. Questionnaires will be conducted at three time points;

1. Before the implementation of the activity program,
2. After the completion of the 8-week activity program (If the activities are set to continue, we will conduct data collection 8 weeks into the program) and
3. At a 3 month follow up.

A range of questionnaires will be used in order to capture different outcomes and impacts.

- For **older residents**, we aim to look at cognition, daily function, quality of Life, Engagement in meaningful activities, depression, self perceived health, loneliness Social Engagement.
- For **Care staff** we aim to look at job satisfaction, social interaction with residents, and job characteristics.

Questionnaires will be used to provide feedback about the overall experience and delivery of the activities. We would also like to conduct more in-depth interviews with four participants who are involved in the activities and have taken part in the previous research questionnaires (1 resident and 1 staff member). We expect these to take approximately 30 minutes and will help the researchers gain a more detailed insight into individual's views and experiences of the activities. The researcher can come and conduct these at a time convenient for the interviewee.

How long will the research take overall?

The time taken to complete the data collection will vary due to a number of factors such as staff availability, health of residents etc. Collection of questionnaire data at each time point (mentioned above) will take between 1 and 2 weeks.

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When will the research data collection commence if approved?

We are looking to collect data from January 2019 to December 2019. Therefore, if your care home is looking to or wanting to set up intergenerational programs lasting at least six weeks during this period, please get in touch. However, please note that the researchers will not be involved in the organisation/setting up of these links.

Participant Selection

- Residents (age ≥ 65 years) who are routinely invited to take part in activities will be invited to participate in screening, where we will measure cognition and daily functioning. Once screening is completed we will invite residents who score sufficiently and able to provide consent to be involved in the research.
- Care staff (Care home manger, Activities co-ordinator, 3 full/part time staff)

Resident Consent

Consent will be an ongoing process throughout the study, renegotiated verbally at each stage of the research. Please get in touch via the contact details below if you have any further questions regarding consent.

Contact Details

For more information, please contact the lead PhD researcher, Kate Howson:

Email: [redacted]
Address: College of Human Sciences & Health Sciences
Haldane Building
Swansea University
Singleton Park, SA2 8PP

[redacted]

Alternatively, please contact ENRICH Cymru at:
Email: stephanie.watts@swansea.ac.uk

Phone: 01792 602034 Address: As above

College of Human and Health Sciences
Coleg y Gwyddorau Dynol ac Iechyd

Swansea University
Prifysgol Abertawe

Exploring the impact of activities and relationships on all stakeholders residing, working and visiting Residential and Nursing Care homes across South Wales

Swansea University has an exciting opportunity for your care home to be involved in research!

Might YOU be interested?

What are we looking for from the Care Home?

This research aims to explore the impact of activities have on those working, residing and visiting Care Homes across South Wales.

Is your Care Home eligible to take part?

The activity programs must actively involve resident's age ≥ 65 years in residential or Nursing Care homes at least once a week for 8 weeks.

What will the research involve?

The research will involve the completion of questionnaires, surveys and interviews, which will be conducted by the researcher within the care home facilities. Questionnaires will be conducted at three time points;

1. Before the implementation of the activity program,
2. After the completion of the 8-week activity program (If the activities are set to continue, we will conduct data collection 8 weeks into the program) and
3. At a 3 month follow up.

A range of questionnaires will be used in order to capture different outcomes and impacts.

- For **older residents**, we aim to look at cognition, daily function, quality of Life, Engagement in meaningful activities, depression, self perceived health, loneliness Social Engagement.
- For **Care staff** we aim to look at job satisfaction, social interaction with residents, and job characteristics.

Questionnaires will be used to provide feedback about the overall experience and delivery of the activities. We would also like to conduct more in-depth interviews with four participants who are involved in the activities and have taken part in the previous research questionnaires (1 resident and 1 staff member). We expect these to take approximately 30 minutes and will help the researchers gain a more detailed insight into individual's views and experiences of the activities. The researcher can come and conduct these at a time convenient for the interviewee.

How long will the research take overall?

The time taken to complete the data collection will vary due to a number of factors such as staff availability, health of residents etc. Collection of questionnaire data at each time point (mentioned above) will take between 1 and 2 weeks.

When will the research data collection commence if approved?

We are looking to collect data from January 2019 to December 2019. Therefore, if your care home is looking to or wanting to set up intergenerational programs lasting at least six weeks during this period, please get in touch. However, please note that the researchers will not be involved in the organisation/setting up of these links.

Participant Selection

- Residents (age ≥ 65 years) who are routinely invited to take part in activities will be invited to participate in screening, where we will measure cognition and daily functioning. Once screening is completed we will invite residents who score sufficiently and able to provide consent to be involved in the research.
- Care staff (Care home manger, Activities co-ordinator, 3 full/part time staff)

Resident Consent

Consent will be an ongoing process throughout the study, renegotiated verbally at each stage of the research. Please get in touch via the contact details below if you have any further questions regarding consent.

Contact Details:

For more information, please contact the lead PhD researcher, Kate Howson:

[redacted]

Address: College of Human Sciences & Health Sciences
Haldane Building
Swansea University
Singleton Park, SA2 8PP

Alternatively, please contact ENRICH Cymru at:

Email: stephanie.watts@swansea.ac.uk

Phone: 01792 602034

Address: *As above*

Participant Information Form - Older Adults

Exploring the impact of activities and relationships on all stakeholders residing, working, and visiting Residential and Nursing Care homes across South Wales

You have been asked to take part in this study because you are over 65 and residing in a residential or nursing home that provides regular activities.

Before you decide whether to participate, it is important for you to understand why the research is being carried out and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand.

We would also encourage you to discuss this invitation with your relatives, friends and other professionals involved in your care if you wish. We would like to stress you do not have to accept this invitation and should only agree to take part if you want to.

Thank you for taking the time to read this.

1. **What is the purpose of the study?**

   Care homes often provide activities for residents. We are interested in the effect different activity programs run in care homes across South Wales have on the care home residents, staff, and the relatives/friends who support you.

2. **Why have I been chosen to take part?**

   You have been invited to take part in this research as you are aged over 65 years old and currently living in a care home where there is a structured activity programme.

3. **Do I have to take part?**

   You do not have to take part in this research. Participation is voluntary and participants are free to withdraw at any time without explanation and without being disadvantaged in any way.

4. **What will happen if I take part?**

   We would like to invite you take part in a screening phase, which will enable us to see if you are able to take part in the study. The researcher will ask you a series of questions relating to your daily activities and memory. This will take approximately 20 minutes. Standard ethical procedures will involve you providing your consent to participate in this study by completing the consent form that has been provided to you. This study is approved by the College of Human and Health Sciences Research Ethics Committee, Swansea University.

5. **Who is carrying out the research?**

   The data are being collected by PhD researcher Kate Howson, from the Centre for Innovative Ageing located within College of Human and Health Sciences.

6. **Expenses and/ or Payments**

   There are no expenses or payment being made to participants.

7. Are there any risks in taking part?

There are no risks involved in taking part. In the unlikely event that you become distressed or if you do not want to answer any of the questions you do not have to.

8. Are there any benefits in taking part?

There are no direct benefits for the individuals who take part in the study. We do however hope that the results will improve the delivery of activities in care homes and identify the most effective ways of improving the quality of life and wellbeing of all those involved.

9. Will my participation be kept confidential?

Swansea University is the sponsor will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. All information that is collected about you for the study will be kept strictly confidential. We will not include your name or any other information that might identify you in the written record of the interview. We will be using information from you to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Swansea University will keep identifiable information about you 6 months after the study, until June 2021.

10. What will happen to the results of the study and how long will my data be stored?

Anonymised data will be stored on a computer for researchers to analyse during the 3-year project. We are likely to present the findings at conferences, on our website and in journal articles. We will not use your name or any other information that might identify you or where you work in the research. Finally, data will be shared on UK Data archive to share the findings of the research.

11. What will happen if I stop taking part, and what are your rights to information?

You can withdraw from the study at any time without explanation and will not affect your participation in any activities. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally identifiable information possible. You can find out more about how we use your information resgov@swansea.ac.uk. Any requests or objections should be made in writing to the University Data Protection Officer:

University Compliance Officer (FOI/DP)
Vice-Chancellor's Office
Swansea University
Singleton Park
Swansea
SA2 8PP
Email: dataprotection@swansea.ac.uk

12. Will my taking part be covered by an insurance scheme?

Participants taking part in this ethically approved study will have insurance cover provided by Swansea University.

13. Who can I contact if I have further questions?

The person in overall charge of this project is Kate Howson. You can call, email, or write to Kate with your questions or concerns using our contact details listed overleaf. Please ask questions as often as you want. You can contact her by phone or email on Monday to Friday between 9 a.m. and 5 p.m.

Participant Information Form - Staff

Exploring the impact of activities and relationships on all stakeholders residing, working, and visiting Residential and Nursing Care homes across South Wales

You are being invited to participate in a research study. Before you decide whether to participate or not, it is important for you to understand why the research is being carried out and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that is unclear.

Thank you for taking the time to read this.

1. **What is the purpose of the study?**

Care homes often provide activities for residents. We are interested in the impact different activity programs run in care homes across South Wales have on the care home residents, staff, and kin/non kin caregivers.

2. **Why have I been chosen to take part?**

You have been invited to take part in this research as you are currently working in a residential/nursing care home that delivers a structured activity program for the residents.

3.Do I have to take part?

You do not have to take part in this research. Participation is voluntary and participants are free to withdraw at any time without explanation and without being disadvantaged in any way.

4. **What will happen if I take part?**

We would like to invite you to complete questionnaires at three different occasions; one initial questionnaire, 8 weeks after and at 3 months follow up. The questionnaires will cover areas relating to your work within the residential care home, such as job characteristics and relationships with residents and each will take approximately 15 minutes. Standard ethical procedures will involve you providing your consent to participate in this study by completing the consent form that has been provided to you. This study is approved by the College of Human and Health Sciences Research Ethics Committee, Swansea University.

5. **Who is carrying out the research?**

The data are being collected by PhD researcher Kate Howson, from the Centre for Innovative Ageing located within College of Human and Health Sciences.

6. **Expenses and/ or Payments**

There are no expenses or payment being made to participants.

7. Are there any risks in taking part?

There are no risks involved in taking part. In the unlikely event that you become distressed or if you do not want to answer any of the questions you do not have to.

8. Are there any benefits in taking part?

There are no direct benefits for the individuals who take part in the study. We do however hope that the results will improve the delivery of activities in care homes and identify the most effective ways of improving the quality of life and wellbeing of all those involved.

9. Will my participation be kept confidential?

Swansea University is the sponsor will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. All information that is collected about you for the study will be kept strictly confidential. We will not include your name or any other information that might identify you in the written record of the interview. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Swansea University will keep identifiable information about you 6 months after the study, until June 2021.

10. What will happen to the results of the study and how long will my data be stored?

Anonymised data will be stored on a computer for researchers to analyse during the 3-year project. We are likely to present the findings at conferences, on our website and in journal articles. We will not use your name or any other information that might identify you or where you work in the research. Finally, data will be shared on UK Data archive to share the findings of the research.

11. What will happen if I stop taking part, and what are your rights to information?

You can withdraw from the study at any time without explanation and will not affect your participation in any activities. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally identifiable information possible. You can find out more about how we use your information resgov@swansea.ac.uk. Any requests or objections should be made in writing to the University Data Protection Officer:

University Compliance Officer (FOI/DP)
Vice-Chancellor's Office
Swansea University
Singleton Park
Swansea
SA2 8PP
Email : dataprotection@swansea.ac.uk

12. Will my taking part be covered by an insurance scheme?

Participants taking part in this ethically approved study will have insurance cover provided by Swansea University.

13. Who can I contact if I have further questions?

The person in overall charge of this project is Kate Howson. You can call, email, or write to Kate with your questions or concerns using our contact details listed overleaf. Please ask questions as often as you want. You can contact her by phone or email on Monday to Friday between 9 a.m. and 5 p.m.

14. Who can I contact if I have a complaint?

If you would like to make a complaint or have there is a problem, please contact Professor Vanessa Burholt (Kate's supervisor). If you remain unhappy, concerned, or have a complaint, with which you feel you cannot contact the supervisor, please contact the Head of Research in the College of Human and Health Sciences, Professor Mark Blagrove (details below). Please provide the name or a description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make. The complaint will then be promptly and impartially investigated, during which time you will be kept fully informed and remain in contact with the investigator.

CONTACT DETAILS

Researcher: Kate Howson
Ageing and Gerontology Studies PhD Student
College of Human and Health Sciences
Centre for Innovative Ageing
Haldane Building
Swansea University
Swansea
SA2 8PP
Tel: [redacted] Email: [redacted]

Research Student Supervisor: Professor Vanessa Burholt
College of Human and Health Sciences
Centre for Innovative Ageing
Haldane Building
Swansea University
Swansea
SA2 8PP
Telephone: (01792) 602186 Email: v.burholt@swansea.ac.uk

Head of Department – College of Human Health Science: Professor Mark Blagrove
College of Human and Health Sciences
Centre for Innovative Ageing
Haldane Building
Swansea University
Swansea
SA2 8PP
Telephone: (01792) 295586 Email: m.t.blagrove@swansea.ac.uk

Appendix 3– Participant consent forms

(QUANT) CONSENT FORM- For Older adults, Care staff and Family/friends

Exploring the impact of activities and relationships on all stakeholders residing, working and visiting Residential and Nursing Care homes across South Wales

Research Student: Kate Howson
Research Supervisor: Professor Vanessa Burholt

Please initial all boxes

1. I (the participant) confirm that I have read and understand the information sheet for the above study and have had the support and opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without it affecting my participation in any activities. ☐
3. I agree to the university anonymously processing personal data that I have supplied for any purposes connected with the Research Project as outlined to me. ☐
4. I have been informed that the confidentiality of the information I provide will be safeguarded. ☐
5. I understand I am free to ask any questions at any time before and during the study. ☐
6. I consent to take part in the above study and have reached this decision without coercion or undue pressure.

Name of participant	Signature	Date
Person Taking Consent	Signature	Date
Print name of researcher	Signature	Date

(QUAL) CONSENT FORM- For Older adults, Care staff and Family/friends

Exploring the impact of activities and relationships on all stakeholders residing, working and visiting Residential and Nursing Care homes across South Wales

Research Student: Kate Howson
Research Supervisor: Professor Vanessa Burholt

Please initial all boxes

1. I (the participant) confirm that I have read and understand the information sheet for the above study and have had the support and opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without it affecting my participation in any activities. ☐
3. I agree to the university anonymously processing personal data that I have supplied for any purposes connected with the Research Project as outlined to me. ☐
4. I have been informed that the confidentiality of the information I provide will be safeguarded. ☐
5. I agree for interviews to be audio recorded. ☐
6. I understand I am free to ask any questions at any time before and during the study. ☐
7. I consent to take part in the above study and have reached this decision without coercion or undue pressure. ☐

Name of participant	Signature	Date
Person Taking Consent	Signature	Date
Print name of researcher	Signature	Date

(Child Age 5-10 years/Guardian) CONSENT FORM

Exploring the impact of activities and relationships on all stakeholders residing, working and visiting Residential and Nursing Care homes across South Wales

Research Student: Kate Howson
Research Supervisor: Professor Vanessa Burholt

1. I (the participant/guardian) confirm that I have read and understand the information sheet for the above study and have had the support and opportunity to ask questions.
2. I understand that my/child's participation is voluntary and that I am/they are free to withdraw at any time without it affecting my participation in any activities.
3. I agree to the university anonymously processing personal data that I/my child have supplied for any purposes connected with the research project as outlined to me.
4. I have been informed that the confidentiality of the information I/my child provide(s) will be safeguarded.
5. I understand I am/my child is free to ask any questions at any time throughout the study.
6. I give consent (for my child) to take part in the above study and have reached this decision without coercion or undue pressure.

PART A TO BE COMPLETED BY THE **PARENT/GUARDIAN**

Name _____ Signature_____ Relationship to child _____ Date_____

PART B TO BE COMPLETED BY THE **RESEARCHER & WITNESS**

Name of Researcher _____ Signature_____ Date _____

Name of Witness _____ Signature _____ Date _____

Name of child _____ Age_____ Witnessed assent provided (Please tick) ☐

A photocopy of this consent form will be available to the guardian/parent via the participating child.

THIS FORM MUST BE COMPLETED AND RETURNED TO THE RESEARCH TEAM FOR THE NAMED YOUNG PERSON TO BE INCLUDED IN THIS STUDY.

(Child aged 11-18 years/Guardian) CONSENT FORM

Exploring the impact of activities and relationships on all stakeholders residing, working and visiting Residential and Nursing Care homes across South Wales

Research Student: Kate Howson
Research Supervisor: Professor Vanessa Burholt

1. I (the participant/guardian) confirm that I have read and understand the information sheet for the above study and have had the support and opportunity to ask questions.
2. I understand that my/my childs participation is voluntary and that I am/they are free to withdraw at any time without it affecting my participation in any activities.
3. I agree to the university anonymously processing personal data that I/my child have supplied for any purposes connected with the research project as outlined to me.
4. I have been informed that the confidentiality of the information I/my child provide(s) will be safeguarded.
5. I understand I/my child can ask any questions at any time throughout the study.
6. I give consent (for my child) to take part in the above study and have reached this decision without coercion or undue pressure.

PART A TO BE COMPLETED BY THE YOUNG PERSON (Age 11-18)

Name _____ Signature _____ Age_____ Date _____

PART B TO BE COMPLETED BY THE PARENT/GUARDIAN

Name _____ Signature_____ Relationship to child _____ Date_____

PART C TO BE COMPLETED BY THE RESEARCHER

Name _____ Signature_____ Date _____

A photocopy of this consent form will be available to the guardian/parent via the participating child.

THIS FORM MUST BE COMPLETED AND RETURNED TO THE RESEARCH TEAM FOR THE NAMED YOUNG PERSON TO BE INCLUDED IN THIS STUDY.

Appendix 4 – Pictures presented to YP for the picture series sub scale of CATE

Picture One

Picture Two

Picture Three

Picture Four

Appendix 5 – Interview guides

Interview Guide 1: **Older adults (intergenerational)**

These questions invite the person to tell their story within specific time boundaries. The aim of these questions if to explore participants experiences, feelings, and attitudes towards the activities they have been engaged in over the past two months.

Questions	*Aims*
1. *What is it like living here?* 2. *What does your typical weekly or daily routine look like?* 3. *Do you have any favourite hobbies?* 4. *What activities have you been involved with?* 5. *How do you feel about the activities run here?* <*why is that?*> < *Can you tell me a little more about that*> 6. *Whilst being involved in the activities was there anything in particular that stood out to you?* 7. *What do you think motivates you to engage in an activity?* 8. *Tell me about any difficulties you might have had doing activities?* 9. *What did you enjoy most?*	General introduction questions to make the participant feel at ease *Personal motivation and experience of activities*
10. How does the care home meet your needs and interests in relation to the activities they run? 11. How well do you think the staff accommodate and tailor the activities to suit your needs and interests?	*Implementation and purpose of activities*

12. What input do you have in planning or choosing which activities you do? 13. How well do you feel the activities with the children were organised and run? 14. Do you think it's a good idea to run and organise these types of activities? 15. What other activities would you have liked to participated in?	
16. What makes an activity meaningful to you? 17. How do you feel generally when taking part in the activities? 18. How do you feel when you know the children come and visit to do the activities with you? 19. What things did you learn from the activities with the children? 20. How would you describe the atmosphere when the children come and visit? 21. Who do you think benefits most from the activities when you and the children are involved and why?	*Significance of activities*
22. To what extent do you think the activities have affected your relationships with other residents? *23. To what extent do you think the activities have affected your relationships with people working here?* *24. To what extent do you think the activities have affected your relationships with your visitors?* *<have you formed any new friendships?>* *25. How do you feel when the children are here?* *26. How would you describe your relationships with the children that have been visiting the care home?*	*Relationships*

27. How do the activities engage the local community?	
28. How well are you made aware of what activities and trips are running? 29. How good are the staff at letting you know about any planned activates and trips? *30. Do you feel the activities with the children affect the quality of your care in any way?* *<Could you give me an example?>* *<How did that make you feel?>*	*Communication*
31. Before the children/YP arrived for the first time, did you have any concerns about them coming to visit? *32. In relation to the activities, is there anything you would change?*	*Issues/ Concerns*

Interview Guide: **Older adults (NON – Intergenerational)**

Questions	*Aims*
1. What is it like living here? *2. What does your typical weekly or daily routine look like?* *3. Do you have any favourite hobbies?* *4. What activities have you been involved with?* *5. How do you feel about the activities run here?* *<why is that?>* *< Can you tell me a little more about that>*	*General introduction questions to make the participant feel at ease* *Personal motivation and experience of activities*

6. *Whilst being involved in the activities was there anything in particular that stood out to you?* 7. *What do you think motivates you to engage in an activity?* 8. *Tell me about any difficulties you might have had doing activities?* 9. *What did you enjoy most?*	
10. *How does the care home meet your needs and interests in relation to the activities they run?* 11. *How do you feel about the range of activities run?* 12. *How well do you think the activities are organised and run?* 13. *How well do you think the staff accommodate and tailor the activities to suit your needs and interests?* 14. *What input do you have in planning or choosing what activities you do?* 15. How much purpose do you think the activities have? 16. What other activities would you have liked to have participated in?	Implementation and purpose of activities
17. *What makes an activity meaningful to you?* 18. *What emotions do you feel when taking part in the activities?* 19. *How would you describe the atmosphere when activities are running?*	Significance of activities
20. *How would you describe the impact of being involved with the activities has on your relationships within the care home?*	Relationships

21. *To what extent do you think the activities have affected your relationships with other residents?* 22. *To what extent do you think the activities have affected your relationships with people working here?* 23. *To what extent do you think the activities have affected your relationships with your visitors?* 24. *How do the activities engage the local community?*	
25. How well are you made aware of what activities and trips are running? *26. How good are the staff at letting you know about any planned activates and trips?* *27. Do you feel the activities* affect the quality of you care in *any way?* *<Could you give me an example?>* *<How did that make you feel?>*	Communication
28. In relation to the activities, is there anything you would change?	Issues/ Concerns

Interview guide 2: **Care Staff (Intergenerational)**

Questions	Aims
1. *Can you tell me what is it like to work here at (insert care home name)* 2. *How involved have you been in the running and delivery of the intergenerational activities?* 3. *Why do you think IG activities are important for the residents?*	These questions invite the person to tell their story within specific time boundaries. The aim of these questions is to explore participant's experiences, feelings and attitudes towards the activities they have

	been engaged in over the past two months. General introduction questions to make the participant feel at ease
4. *How does it make you feel seeing the children interact with the residents?* 5. *What surprised you the most about the activities?* 6. *Before the children/YP arrived for the first time, did you have any concerns about them coming to visit?* 7. *Did you have any concerns before the start of intergenerational programme began?* *<If so, what were they?>* *<Have your views changed over time?>* 8. *Who do you think benefits most from the intergenerational programme and why?* 9. *Do you think the IG activities with the children engage residents and family/friends, more so than other activities?*	Reflection on the intergenerational activities programme These are to prompt the interviewee to reflect on their experiences and their perception of the benefits or dis-benefits of intergenerational activities.
10. *How much do the activities run in the care home engage residents?* *<In what way?>* *<Can you give me any examples?>* 11. *What benefits, if any, do you feel the IG activities have on the residents of the care home?* 12. *In what way do the IG activities have on your communication with residents?* 13. *How much do the activities run in the care home engage friends and family?*	Communication
14. *Have you noticed a change in the residents who took part in the intergenerational activities?* 15. *Have the activities impacted on your relationships with with residents' family and friends?*	Relationships

16. *What impact do activities have on your relationships with the residents who are involved?*	
17. *Would you say the activities run bring a sense of added value to your work?* *<Are they impactful on yourselves or is your main focus on the residents?>* 18. *Do you think activities add further to your workload?* *<If yes, do you think its value outweighs the added workload?>* *<Why do you think this?>* *<could you explain further?>* 19. *How much would you say the activities run in the care home have impacted upon yourself?*	Work Satisfaction
20. *How do perceived roles of staff affect involvement in activities with the residents?* *<Would you say some care staff see activities as 'not part of their job'>* 21. *How much do you think the activities with the children have the power to change communities' views of care homes?* *<Why do you think this?>* 22. *What affect do you think intergenerational activities run in the care home or shared sites, could have on staff retention and recruitment in the social care sector?*	Beliefs These questions aim to get insight into whether care staff believe that intergenerational activities can make a difference to social care staff dynamics.
23. Would you say the training and support you receive to carry out or be involved in the activities is sufficient? 24. Did you have any concerns about the activities? If so, what were they? 25. Have you learnt anything from being involved in the activities? 26. Would you have changed anything about the activities?	Issues/Concerns

27. What challenges have you faced in relation to the running of the activities?	

Interview guide 2: **Care Staff (Non-Intergenerational)**

These questions invite the person to tell their story within specific time boundaries. The aim of these questions is to explore participants' experiences, feelings and attitudes towards the activities they have been engaged in over the past two months.

Questions	Aims
1. *Can you tell me what is it like to work here at (insert care home name)* 2. *How involved have you been in the running and delivery of the activities?* 3. *What have your experiences been of the activities run over the last month or so?* *<How do you feel when running the activities?>* 4. *Why do you think activities are important for the residents?*	General introduction questions to make the participant feel at ease Personal motivation and experience of activities
5. *In what way do you believe the activities are valued by and matter to the residents?* 6. *In what way do you believe the activities are valued by and matter to people working here?* 7. *Have the activities gone as hoped?* 8. *What, if anything, would you have changed about the activities?* 9. *What challenges have you faced in relation to the running of the activities?* 10. *What do you think works well?* *<Can you give me any examples?>* 11. *How much do you think the activities engage residents?*	Implementation and purpose of activities

12. *How much do you think the activities engage and family/friends?*	
13. *In terms of communicating with one another What benefits, if any, do you feel the activities have on the residents* 14. *In what ways if any have the activities impacted upon our communication with residents?*	Communication
15. *Have you noticed any changes in any of the residents who take part in the activities, for example in forming new relationships?* 16. *How have the activities impacted on your relationships with residents and family/friends of residents?* 17. *To what extent do you feel the activities were meaningful and engaging for the residents?* <*why do you think this is?*>	Relationships
18. *How much would you say the activities run in the care home have impacted you?* 19. *To what extent do you think activities add further to your workload?* <*Why do you think this?*> <*could you explain further?*> 20. *Would you say the activities run have brought more of a sense of purpose to your work?* <*Are they impactful on yourselves or is your main focus on the residents?*>	Work Satisfaction
21. *Overall would you say some care staff see activities as 'not part of their job'?* <*In what way?*> 22. *What contribution do other staff have towards the planning of activities?*	Beliefs

<Do others recognise and contribute to the activities?> *<Do the activities enhance staff morale and cohesion?>* 23. *How important do you think it is to engage with and link into the local community?* *<do you have examples of this and the difference its made?>* 24. *How much do you think the activities the care home runs have the power to change what communities think about care homes?* *<Why do you think this?>* 25. *Do you think this could entice more staff into the care sector?>*	
26. *Overall, would you say the training and support you receive to carry out or be involved in the activities is sufficient?* 27. *Did you have any concerns about the activities? If so, what were they?* 28. *What has being involved in the activities taught you?* 29. *What, if anything, would you change about the activities?*	Issues/Concerns

Appendix 6 – Debrief form

PARITICPANT DEBRIEF FORM

Thank you for taking part in our research!

The aim of this research was to explore whether involvement in the activity programme you have been participating in over the last two months has had an impact on yourself. We wanted to explore your experiences of views on the activity programme as well as any changes you might have experienced over time in relation to the running of the activity programme. This is why we asked to speak to you both, before and after the activity programme.

We hope that the findings from this research will be used to contribute to the creation of age friendly communities in care homes and places where meaningful activities and relationships can be nurtured.

If you have further questions about this research or would like to keep in touch in relation to the findings of this study send an email to Kate Howson [redacted] or alternatively write to us at the following address:

Kate Howson

Room 117

Haldane Building

Centre for Innovative Ageing,

College of Human and Health Sciences

Swansea University

Appendix 7 – Care Staff questionnaires

Swansea University
Prifysgol Abertawe
College of Human and Health Sciences
Coleg y Gwyddorau Dynol ac Iechyd

QUESTIONNARE FOR CARE STAFF (T1 and T3)

Exploring the impact of activities and relationships on all stakeholders residing, working and visiting Residential and Nursing Care homes across South Wales

As part of this research funded by the Wales School of Social Care Research, we would like to invite you to take part in some research. This questionnaire has been designed to help capture any impact that activities run in the Care Home may have on you, your work environment and your relationships within the care settings. This information may be used to inform the development of similar activities, reporting about the different activity programmes and in publications.

How to complete the questionnaire.

The questionnaire is divided into two columns in the left hand column you will find the questions. The right hand column is for your answers.

Please read and think about the statement that are in **bold** and enter a response if required, or tick the box on the right hand side, which most closely describes your situation. Please tick only one box for each question. We would like to remind you that your participation is voluntary, all information that is collected will be kept confidential, and your identity will remain anonymous. You may choose not to answer all the questions, however, we would really like you to try and complete the questionnaire. Incomplete questionnaires will make it very difficult for us to evaluate any impact the activities have had.

DATE…….

CARE HOME NAME……..

PARTICIPANT ID NUMBER: ……. (To be completed by researcher)

---------- START OF QUESTIONNAIRE----------

1. How old are you? Age in Years……

2. What is your gender?
   - Male ☐
   - Female ☐
   - Non-binary ☐
   - Prefer not to say ☐

3. What is your marital status?
   - Single ☐
   - Married ☐
   - Civil partnered ☐
   - Divorced ☐
   - Widowed ☐

4. What is the highest education or school qualification you have obtained?
   - Degree or equivalent ☐
   - Higher education ☐
   - A Level or equivalent ☐
   - GCSEs grades A*-C or equivalent ☐
   - Other qualifications ☐
   - No qualification ☐

5. What is your contracted working hours?
   - Full Time ☐
   - Part Time ☐
   - Student ☐
   - Other ☐

6. What is your job title?
   - Care Home Manager ☐
   - Nurse/Senior Carer ☐
   - Care Assistant ☐
   - Activity Co-ordinator ☐
   - Other ☐

7. How long have you worked in this care home? ……. Month/s……...Year/s

8. Choose one option that best describes your ethnic group or background.
   - White British ☐
   - Mixed/Multiple ethnic groups ☐
   - Asian/ Asian British ☐
   - Black/ African/ Caribbean British ☐
   - Chinese ☐
   - Arab ☐
   - Other ethnic group ☐

The next few questions are about your views towards your job satisfaction and its characteristics. Please respond by ticking the appropriate boxes blow.

	Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatis
1. The feeling of worthwhile accomplishment I get from my work	☐	☐	☐	☐	☐
2. The extent to which I can use my skills	☐	☐	☐	☐	☐
3. The extent to which my job is varied and interesting	☐	☐	☐	☐	☐
4. The amount of personal growth and development I get from my work	☐	☐	☐	☐	☐
5. The amount of independent thought and action I can exercise in my work	☐	☐	☐	☐	☐
6. The time available for resident care	☐	☐	☐	☐	☐
7. My workload	☐	☐	☐	☐	☐
8. Overall staffing levels	☐	☐	☐	☐	☐
9. The amount of time spent on administration	☐	☐	☐	☐	☐
10. The degree to which I am fairly paid for what I contribute to this organisation	☐	☐	☐	☐	☐
11. The people I talk to and work with	☐	☐	☐	☐	☐

12. The contact I have with colleagues	☐	☐	☐	☐	☐
13. The value placed on my work by my colleagues	☐	☐	☐	☐	☐
14. The opportunity to attend courses	☐	☐	☐	☐	☐
15. Time off to attend courses	☐	☐	☐	☐	☐
16. Being funded for courses	☐	☐	☐	☐	☐
17. The extent to which I have adequate training for what I do	☐	☐	☐	☐	☐
18. The amount of support and guidance I receive	☐	☐	☐	☐	☐
19. The opportunities I have to discuss my concerns	☐	☐	☐	☐	☐
20. The support available to me in my job	☐	☐	☐	☐	☐
21. The overall quality of the supervision I receive in my work	☐	☐	☐	☐	☐
22. The degree of respect and fair treatment I receive from my boss	☐	☐	☐	☐	☐

The next few questions ask you to consider some statements about people with memory difficulties. Please ticket the extent to which you agree or disagree with the following statements. The scale ranges from *strongly agree* to *strongly disagree*.

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
23. It is important to have a very strict routine when working with people with dementia	☐	☐	☐	☐	☐
24. People with dementia are very much like children	☐	☐	☐	☐	☐
25. There is no hope for people with dementia	☐	☐	☐	☐	☐
26. People with dementia are unable to make decisions themselves	☐	☐	☐	☐	☐
27. It is important for people with dementia to continue to be active and involved in things they enjoy	☐	☐	☐	☐	☐
28. People with dementia are sick and they need to be looked after	☐	☐	☐	☐	☐
29. It is important for people with dementia to be given as much choice as possible in their daily lives	☐	☐	☐	☐	☐
30. Nothing can be done for people with dementia, except for keeping them clean and comfortable	☐	☐	☐	☐	☐
31. People with dementia are more likely to be contented when treated with understanding and reassurance	☐	☐	☐	☐	☐
32. Once dementia develops in a person, it is inevitable that they will go down hill.	☐	☐	☐	☐	☐
33. People with dementia need to feel respected just like anybody else	☐	☐	☐	☐	☐

The next few questions ask you to consider some statements about people with memory difficulties. Please ticket the extent to which you agree or disagree with the following statements. The scale ranges from *strongly agree* to *strongly disagree*.

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
34. Achieving a good quality life for people with dementia involves taking account of their psychological and social needs as well as their physical needs.	☐	☐	☐	☐	☐
35. It is important not to get too attached with someone who has dementia.	☐	☐	☐	☐	☐
36. It doesn't matter what you say to people with dementia because they forget it anyway	☐	☐	☐	☐	☐
37. People with dementia often have good reasons for behaving as they do	☐	☐	☐	☐	☐
38. Spending time with people with dementia can be very enjoyable	☐	☐	☐	☐	☐
39. It is important to respond to people with dementia with empathy and understanding	☐	☐	☐	☐	☐
40. There are lots of things that people with dementia can do	☐	☐	☐	☐	☐
41. People with dementia are just ordinary people who need particular understanding to fulfil their needs	☐	☐	☐	☐	☐

On the scale below, with none being (1) and (5) being a lot, please circle the NUMBER that represents your answer on the following questions.

How much of each kind of opportunity do you have in your present job?

	None				A Lot
42. Challenging work	1	2	3	4	5
43. The chance to gain new skills and knowledge on the job	1	2	3	4	5
44. Tasks that use all of your own skills and Knowledge	1	2	3	4	5

How much access to information do you have in your job?

45. The current state of the care home	1	2	3	4	5
46. The values of top management	1	2	3	4	5
47. The goals of top management	1	2	3	4	5

How much access to support do you have in your job?

48. Specific information about things you do well	1	2	3	4	5
49. Specific comments about things you could improve	1	2	3	4	5
50. Helpful hints or problem solving advice.	1	2	3	4	5

How much access to resources do you have in your present job?

51. Time available to do necessary paperwork	1	2	3	4	5
52. Time available to accomplish job requirements	1	2	3	4	5
53. Acquiring temporary help when needed	1	2	3	4	5

The following statements express situations and thoughts or feelings which can arise when caring for people with dementia. We want to find out how often you

encounter these situations and feelings and, when they occur, how much stress they cause you. ***Please mark the box that best correspond to your experience.***

Situation, thought or feeling	How frequently do you experience these situations, thoughts or feelings?				When they do occur, how stress does it cause you?			
	Never	Some-times	Quite Often	Very often	None	Mild Stress	Moderate stress	
54. I feel that my work is not valued by others.	☐	☐	☐	☐	☐	☐	☐	
55. I find it difficult to understand what residents are experiencing or feeling.	☐	☐	☐	☐	☐	☐	☐	
56. I want to do much more for residents than my employers allow me to.	☐	☐	☐	☐	☐	☐	☐	
57. My employers do not appreciate the work I am doing.	☐	☐	☐	☐	☐	☐	☐	
58. I have difficulty understanding what residents are trying to communicate.	☐	☐	☐	☐	☐	☐	☐	
59. I have difficulty understanding the needs of residents.	☐	☐	☐	☐	☐	☐	☐	
60. I find it difficult to know what is best for residents.	☐	☐	☐	☐	☐	☐	☐	
61. I worry I might upset or hurt a resident because I do not understand his or her needs.	☐	☐	☐	☐	☐	☐	☐	
62. When a resident dies or has to move I feel as though I have lost a relative or close friend.	☐	☐	☐	☐	☐	☐	☐	
63. I can not understand why residents behave the way they do.	☐	☐	☐	☐	☐	☐	☐	
64. I find it difficult to explain to residents what is happening in situations which may upset them (e.g. bathing or toileting)	☐	☐	☐	☐	☐	☐	☐	
65. I have to balance the needs of a resident against the needs or demands of his or her family	☐	☐	☐	☐	☐	☐	☐	
Situation, thought or feeling	**How frequently do you experience these situations, thoughts or feelings?**				**When they do occur, how m stress does it cause you?**			
	Never occurs	Some-times	Quite Often	Very often	No stress	Mild Stress	Moderate stress	

66. I have to balance the needs of a resident against the needs or demands of other residents.	☐	☐	☐	☐		☐	☐	☐
67. I have to prioritise based on urgency rather than fairness or the needs of residents.	☐	☐	☐	☐		☐	☐	☐
68. I feel the residents are highly dependent on me.	☐	☐	☐	☐		☐	☐	☐
69. I wish I knew more about residents so that I could understand them better.	☐	☐	☐	☐		☐	☐	☐
70. I can't stop thinking about residents when I am away from work.	☐	☐	☐	☐		☐	☐	☐
71. I see other staff behaving towards a resident in a way which shows they do not understand the effects of dementia.	☐	☐	☐	☐		☐	☐	☐
72. The families of residents do not seem to understand how difficult it is to care for their relative.	☐	☐	☐	☐		☐	☐	☐
73. Residents resist the care I want to/need to provide.	☐	☐	☐	☐		☐	☐	☐
74. I have to balance the safety of a resident against their quality of life (e.g. using restraint).	☐	☐	☐	☐		☐	☐	☐
75. I see that a resident is suffering.	☐	☐	☐	☐		☐	☐	☐
76. Residents do not receive the care I feel they are entitled to.	☐	☐	☐	☐		☐	☐	☐
77. I see how the family of a resident is suffering.	☐	☐	☐	☐		☐	☐	☐
78. I see residents being mistreated by their family.	☐	☐	☐	☐		☐	☐	☐
79. I see other staff treating a resident badly.	☐	☐	☐	☐		☐	☐	☐
80. Other staff change what I have tried to do for a resident.	☐	☐	☐	☐		☐	☐	☐

During a day or work how often do you experience the following emotions?
On the scale with '*Never' being (1)* and '*All the time' being (5)*, please mark the box that best corresponds to your experience over the few weeks.

	Never 1	2	3	4	5	All the tim 6
81. Powerlessness	☐	☐	☐	☐	☐	☐
82. Satisfaction	☐	☐	☐	☐	☐	☐
83. Sadness	☐	☐	☐	☐	☐	☐
84. Frustration	☐	☐	☐	☐	☐	☐
85. Fear	☐	☐	☐	☐	☐	☐
86. Joy/Happiness	☐	☐	☐	☐	☐	☐

Thank you for answering these questions. Please remember to return this questionnaire to the researcher as soon as possible.

Swansea University
Prifysgol Abertawe
College of Human and Health Sciences
Coleg y Gwyddorau Dynol ac Iechyd

CARE STAFF QUESTIONNAIRE (T2)

Exploring the impact of activities and relationships on all stakeholders residing, working and visiting Residential and Nursing Care homes across South Wales

As part of this research funded by the Wales School of Social Care Research, we would like to invite you to take part in some research. This questionnaire has been designed to help capture any impact that activities run in the Care Home may have on you, your work environment and your relationships within the care settings. This information may be used to inform the development of similar activities, reporting about the different activity programmes and in publications.

How to complete the questionnaire.

The questionnaire is divided into two columns in the left hand column you will find the questions. The right hand column is for your answers.

Please read and think about the statement that are in **bold** and enter a response if required, or tick the box on the right hand side, which most closely describes your situation. Please tick only one box for each question. We would like to remind you that your participation is voluntary, all information that is collected will be kept confidential, and your identity will remain anonymous. You may choose not to answer all the questions, however, we would really like you to try and complete the questionnaire. Incomplete questionnaires will make it very difficult for us to evaluate any impact the activities has had.

DATE……..

PARTICIPANT ID NUMBER: ……. (To be completed by researcher)

---------- START OF QUESTIONNAIRE----------

The next few questions are about your views towards your job satisfaction and its characteristics. Please respond by ticking the appropriate boxes blow.

	Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatis
1. The feeling of worthwhile accomplishment I get from my work	☐	☐	☐	☐	☐
2. The extent to which I can use my skills	☐	☐	☐	☐	☐
3. The extent to which my job is varied and interesting	☐	☐	☐	☐	☐
4. The amount of personal growth and development I get from my work	☐	☐	☐	☐	☐
5. The amount of independent thought and action I can exercise in my work	☐	☐	☐	☐	☐
6. The time available for resident care	☐	☐	☐	☐	☐
7. My workload	☐	☐	☐	☐	☐
8. Overall staffing levels	☐	☐	☐	☐	☐
9. The amount of time spent on administration	☐	☐	☐	☐	☐
10. The degree to which I am fairly paid for what I contribute to this organisation	☐	☐	☐	☐	☐

11. The people I talk to and work with	☐	☐	☐	☐	☐
12. The contact I have with colleagues	☐	☐	☐	☐	☐
13. The value placed on my work by my colleagues	☐	☐	☐	☐	☐
14. The opportunity to attend courses	☐	☐	☐	☐	☐
15. Time off to attend courses	☐	☐	☐	☐	☐
16. Being funded for courses	☐	☐	☐	☐	☐
17. The extent to which I have adequate training for what I do	☐	☐	☐	☐	☐
18. The amount of support and guidance I receive	☐	☐	☐	☐	☐
19. The opportunities I have to discuss my concerns	☐	☐	☐	☐	☐
20. The support available to me in my job	☐	☐	☐	☐	☐
21. The overall quality of the supervision I receive in my work	☐	☐	☐	☐	☐
22. The degree of respect and fair treatment I receive from my boss	☐	☐	☐	☐	☐

The next few questions ask you to consider some statements about people with memory difficulties. Please ticket the extent to which you agree or disagree with the following statements. The scale ranges from *strongly agree* to *strongly disagree*.

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
23. It is important to have a very strict routine when working with people with dementia	☐	☐	☐	☐	☐
24. People with dementia are very much like children	☐	☐	☐	☐	☐
25. There is no hope for people with dementia	☐	☐	☐	☐	☐
26. People with dementia are unable to make decisions themselves	☐	☐	☐	☐	☐
27. It is important for people with dementia to continue to be active and involved in things they enjoy	☐	☐	☐	☐	☐
28. People with dementia are sick and they need to be looked after	☐	☐	☐	☐	☐
29. It is important for people with dementia to be given as much choice as possible in their daily lives	☐	☐	☐	☐	☐
30. Nothing can be done for people with dementia, except for keeping them clean and comfortable	☐	☐	☐	☐	☐
31. People with dementia are more likely to be contented when treated with understanding and reassurance	☐	☐	☐	☐	☐
32. Once dementia develops in a person, it is inevitable that they will go down hill.	☐	☐	☐	☐	☐

The next few questions ask you to consider some statements about people with memory difficulties. Please ticket the extent to which you agree or disagree with the following statements. The scale ranges from *strongly agree* to *strongly disagree*.

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
33. People with dementia need to feel respected just like anybody else	☐	☐	☐	☐	☐
34. Achieving a good quality life for people with dementia involves taking account of their psychological and social needs as well as their physical needs.	☐	☐	☐	☐	☐
35. It is important not to get too attached with someone who has dementia.	☐	☐	☐	☐	☐
36. It doesn't matter what you say to people with dementia because they forget it anyway	☐	☐	☐	☐	☐
37. People with dementia often have good reasons for behaving as they do	☐	☐	☐	☐	☐
38. Spending time with people with dementia can be very enjoyable	☐	☐	☐	☐	☐
39. It is important to respond to people with dementia with empathy and understanding	☐	☐	☐	☐	☐
40. There are lots of things that people with dementia can do	☐	☐	☐	☐	☐
41. People with dementia are just ordinary people who need particular understanding to fulfil their needs	☐	☐	☐	☐	☐

On the scale below, with none being (1) and (5) being a lot, please circle the NUMBER that represents your answer on the following questions.

How much of each kind of opportunity do you have in your present job?

	None				A Lot
42. Challenging work	1	2	3	4	5
43. The chance to gain new skills and knowledge on the job	1	2	3	4	5
44. Tasks that use all of your own skills and Knowledge	1	2	3	4	5

How much access to information do you have in your job?

45. The current state of the care home	1	2	3	4	5
46. The values of top management	1	2	3	4	5
47. The goals of top management	1	2	3	4	5

How much access to support do you have in your job?

48. Specific information about things you do well	1	2	3	4	5
49. Specific comments about things you could improve	1	2	3	4	5
50. Helpful hints or problem solving advice.	1	2	3	4	5

How much access to resources do you have in your present job?

51. Time available to do necessary paperwork	1	2	3	4	5
52. Time available to accomplish job requirements	1	2	3	4	5
53. Acquiring temporary help when needed	1	2	3	4	5

The following statements express situations and thoughts or feelings which can arise when caring for people with dementia. We want to find out how often you encounter these situations and feelings and, when they occur, how much stress they cause you. ***Please mark the box that best correspond to your experience.***

Situation, thought or feeling	How frequently do you experience these situations, thoughts or feelings?				When they do occur, how stress does it cause you?			
	Never	Some-times	Quite Often	Very often	None	Mild Stress	Moderate stress	
54. I feel that my work is not valued by others.	☐	☐	☐	☐	☐	☐	☐	
55. I find it difficult to understand what residents are experiencing or feeling.	☐	☐	☐	☐	☐	☐	☐	
56. I want to do much more for residents than my employers allow me to.	☐	☐	☐	☐	☐	☐	☐	
57. My employers do not appreciate the work I am doing.	☐	☐	☐	☐	☐	☐	☐	
58. I have difficulty understanding what residents are trying to communicate.	☐	☐	☐	☐	☐	☐	☐	
59. I have difficulty understanding the needs of residents.	☐	☐	☐	☐	☐	☐	☐	
60. I find it difficult to know what is best for residents.	☐	☐	☐	☐	☐	☐	☐	
61. I worry I might upset or hurt a resident because I do not understand his or her needs.	☐	☐	☐	☐	☐	☐	☐	
62. When a resident dies or has to move I feel as though I have lost a relative or close friend.	☐	☐	☐	☐	☐	☐	☐	
63. I can not understand why residents behave the way they do.	☐	☐	☐	☐	☐	☐	☐	
64. I find it difficult to explain to residents what is happening in situations which may upset them (e.g. bathing or toileting)	☐	☐	☐	☐	☐	☐	☐	
65. I have to balance the needs of a resident against the needs or demands of his or her family	☐	☐	☐	☐	☐	☐	☐	

Situation, thought or feeling	How frequently do you experience these situations, thoughts or feelings?				When they do occur, how m stress does it cause you?		
	Never occurs	Some-times	Quite Often	Very often	No stress	Mild Stress	Moderate stress
66. I have to balance the needs of a resident against the needs or demands of other residents.	☐	☐	☐	☐	☐	☐	☐
67. I have to prioritise based on urgency rather than fairness or the needs of residents.	☐	☐	☐	☐	☐	☐	☐
68. I feel the residents are highly dependent on me.	☐	☐	☐	☐	☐	☐	☐
69. I wish I knew more about residents so that I could understand them better.	☐	☐	☐	☐	☐	☐	☐
70. I can't stop thinking about residents when I am away from work.	☐	☐	☐	☐	☐	☐	☐
71. I see other staff behaving towards a resident in a way which shows they do not understand the effects of dementia.	☐	☐	☐	☐	☐	☐	☐
72. The families of residents do not seem to understand how difficult it is to care for their relative.	☐	☐	☐	☐	☐	☐	☐
73. Residents resist the care I want to/need to provide.	☐	☐	☐	☐	☐	☐	☐
74. I have to balance the safety of a resident against their quality of life (e.g. using restraint).	☐	☐	☐	☐	☐	☐	☐
75. I see that a resident is suffering.	☐	☐	☐	☐	☐	☐	☐
76. Residents do not receive the care I feel they are entitled to.	☐	☐	☐	☐	☐	☐	☐
77. I see how the family of a resident is suffering.	☐	☐	☐	☐	☐	☐	☐
78. I see residents being mistreated by their family.	☐	☐	☐	☐	☐	☐	☐
79. I see other staff treating a resident badly.	☐	☐	☐	☐	☐	☐	☐
80. Other staff change what I have tried to do for a resident.	☐	☐	☐	☐	☐	☐	☐

During a day or work how often do you experience the following emotions?
On the scale with '*Never' being (1)* and '*All the time' being (5)*, please mark the box that best corresponds to your experience over the few weeks.

	Never 1	2	3	4	5	**All the tim** 6
81. Powerlessness	☐	☐	☐	☐	☐	☐
82. Satisfaction	☐	☐	☐	☐	☐	☐
83. Sadness	☐	☐	☐	☐	☐	☐
84. Frustration	☐	☐	☐	☐	☐	☐
85. Fear	☐	☐	☐	☐	☐	☐
86. Joy/Happiness	☐	☐	☐	☐	☐	☐

The final section will ask you about your feedback experiences of the activities being run in the care home over the last couple of weeks

87. What benefits, if any, do you feel the activities have on the residents taking part?

88. To what extent do you agree that the following were appropriate in relation to the activities run in the care home (Please tick):

	Strongly Agree	Agree	No strong Opinion	Disagree	Strongly Disagree	I don't Know

Number of Sessions						
Duration of Session						
Time of Day						
Ratio of Staff/Facilitators to Participants						
The facilities						
Training provided to care staff to conduct activities						
Total Number of Participants per session						

Further comments…

89. To what extent do you agree that the following statements (Please tick):

	Strongly Agree	Agree	No strong Opinion	Disagree	Strongly Disagree	I don't Know
The staffing levels allow you to provide the level of stimulation and engagement you would like						
It's challenging to regularly engage the residents						
The activities have been implemented and delivered as intended						

90. Were there any challenges or problems that you came across with the implementation of activities?

☐ Yes ☐ No ☐ I don't know If yes, Please explain furthe

91. Please indicate your views in answer to the below statements:

	Yes, Positive/ly	Yes, Negative/ly	No Change	I don't know
The activities in the care home engaged and impacted upon people from the wider community				
The activities take away time from your other duties of care				
You see a different side the residents when they engage in the activities				
You sense a change of spirit/atmosphere in the Care Home when activities are being carried out				
Being involved with the activities altered your mood				

92. If you or a loved one needed care services, would you prefer a care setting where there are opportunities/activities to interact with people of different age groups such as younger children?

☐ Yes
☐ No
☐ I don't know
☐ No strong opinion

93. If the opportunity arose and you had children who were attending nursery, would you prefer to send them to a nursery that was collocated in a care home, or a single site nursery?

☐ Shared site nursery

- [ ] Single site nursery
- [ ] I don’t know
- [ ] No strong opinion

94. Overall, how satisfied have you been with how the activities have gone?

Very Satisfied	Satisfied	Neither satisfied nor unsatisfied	Unsatisfied	Very Unsatisfied
○	○	○	○	○

Thank you for answering these questions. Please remember to return this questionnaire to the researcher as soon as possible.

Appendix 8 – Older Adults Questionnaires

Exploring the impact of activities and relationships on all stakeholders residing, working and visiting Residential and Nursing Care homes across South Wales

Older adults Questionnaire and manual (T1/T3)

SECTION A

Care Home Name: _____

Name of Interviewee: _____

Date of Interview: _____

Participants ID: _____

INTERVIEW STATUS Complete Incomplete

Reason why interview is incomplete (if applicable)

- Resident fatigue
- Refusal to continue
- Resident illness
- Unable to respond to questions
- Necessary clinical care
- Other

---------- START OF INTERVIEW ----------

Thank you for agreeing to be interviewed. Your help is extremely valuable to us and of course any information you provide will be treated in strictest confidence.

You are able to stop the interview at any point in time. Are you still happy to go ahead with these questions?

9. **How old are you?** Age in Years……

10 **What is your gender?**

- Male ☐
- Female ☐
- Non-binary ☐
- Prefer not to say ☐

11 **What is your marital status?**

- Single ☐
- Co-habiting ☐
- Married ☐
- Widowed ☐
- Separated ☐
- Divorced ☐
- Civil Partnership ☐

12 **What is the highest education or school qualification you have obtained?**

- Degree or equivalent ☐
- Higher education ☐
- A Level or equivalent ☐
- GCSEs grades A*-C or equivalent ☐
- Other qualifications ☐
- No qualification ☐

13 **How long have you lived here**? ……. Month/s……...Year/s

14 **Choose one option that best describes your ethnic group or background.**

- White British ☐
- Mixed/Multiple ethnic groups ☐
- Asian/ Asian British ☐
- Black/ African/ Caribbean British ☐
- Chinese ☐
- Arab ☐
- Other ethnic group ☐

I would now like to ask you about your life. There are no right or wrong answers. Just give the answer that best describes how you have felt in the last week. Do not worry if some of the questions appear not to apply to you. We have to ask the same questions to everybody.

Before we start, we will do a practice question; this one will not count. (Show the response card and ask the participant to say or point

to the answer). **In the last week, how much have you enjoyed watching television?**

A lot **Quite a bit** **A little** **Not at all**

Just as the practice question I asked you, I want you to think about the next few questions in relation to how you felt last week. First, I am going to ask about your feelings. So, in the last week, have you felt……. (CIRCLE APPROPRIATE ANSWER)				
1. Cheerful?	A lot	Quite a bit	A little	Not at all
2. Worried or anxious?	A lot	Quite a bit	A little	Not at all
3. That you are enjoying life?	A lot	Quite a bit	A little	Not at all
4. Frustrated?	A lot	Quite a bit	A little	Not at all
5. Confident?	A lot	Quite a bit	A little	Not at all
6. Full of energy?	A lot	Quite a bit	A little	Not at all
7. Sad?	A lot	Quite a bit	A little	Not at all
8. Lonely?	A lot	Quite a bit	A little	Not at all
9. Distressed?	A lot	Quite a bit	A little	Not at all
10. Lively?	A lot	Quite a bit	A little	Not at all
11. Irritable?	A lot	Quite a bit	A little	Not at all
	A lot	Quite a bit	A little	Not at all

12. Fed-up?				
13. That there are things that you wanted to do but couldn't?	A lot	Quite a bit	A little	Not at all
Next im going to ask about your memory. In the last week, how worried have you been about……				
14. Forgetting things that happened recently?	A lot	Quite a bit	A little	Not at all
15. Forgetting who people are?	A lot	Quite a bit	A little	Not at all
16. Forgetting what day it is?	A lot	Quite a bit	A little	Not at all
17. Your thoughts being muddled?	A lot	Quite a bit	A little	Not at all
18. Difficulty making decisions?	A lot	Quite a bit	A little	Not at all
19. Poor concentration?	A lot	Quite a bit	A little	Not at all
Now im going to ask you about your everyday life. In the last week, how worried have you been about?.....				
20. Not having enough company?	A lot	Quite a bit	A little	Not at all
21. How you get on with people close to you?	A lot	Quite a bit	A little	Not at all
22. Getting the affection you want?	A lot	Quite a bit	A little	Not at all

23. People not listening to you?	A lot	Quite a bit	A little	Not at all
24. Making yourself understood?	A lot	Quite a bit	A little	Not at all
25. Getting help when you need it?	A lot	Quite a bit	A little	Not at all
26. Getting to the toilet in time?	A lot	Quite a bit	A little	Not at all
27. How you feel in yourself?	A lot	Quite a bit	A little	Not at all
28. Your health overall?	A lot	Quite a bit	A little	Not at all
We've already talked about lots of things: your feelings, memory, and everyday life. Thinking about all of these things in the last week, how would you rate……				
29. Your overall quality of life?	Very good	Good	Fair	Poor

Now we would like to ask you some general questions about your time living here in the care home, as well as your health and wellbeing.

I am going to read out a number of statements and I would like you to indicate the answer that best describes to what extent each statement is true for you, on this scale.	Rarely	Sometimes	Usually	Always
30. The activities you do help you take care of yourself.	Rarely	Sometimes	Usually	Always

31. The activities you do reflect the kind of person you are.	Rarely	Sometimes	Usually	Always
32. The activities you do express your creativity	Rarely	Sometimes	Usually	Always
33. The activities you do help you achieve something which gives you a sense of accomplishment.	Rarely	Sometimes	Usually	Always
34. The activities you do contribute to your feelings of competence.	Rarely	Sometimes	Usually	Always
35. The activities you do are valued by other people.	Rarely	Sometimes	Usually	Always
36. The activities you do help other people.	Rarely	Sometimes	Usually	Always
37. The activities you do give you pleasure	Rarely	Sometimes	Usually	Always
38. The activities you do give you a feeling of control.	Rarely	Sometimes	Usually	Always
39. The activities you do help you express your personal values.	Rarely	Sometimes	Usually	Always
40. The activities you do give you a sense of satisfaction.	Rarely	Sometimes	Usually	Always

41. The activities you do have just the right amount of challenge	Rarely	Sometimes	Usually	Always
Now I would like you to please answer 'YES' or 'NO' to the following questions.				
42. Are you basically satisfied with your life?	YES / NO			
43. Do you often get bored?	YES / NO			
44. Do you often feel helpless?	YES / NO			
45. Do you prefer to stay at home, rather than going out and doing new things?	YES / NO			
46. Do you feel pretty worthless the way you are now?	YES / NO			
47. Have you dropped many of your activities and interests?	YES / NO			
48. Do you feel your life is empty?	YES / NO			
49. Are you in good spirits most of the time?	YES / NO			
50. Are you afraid something bad is going to happen to you?	YES / NO			
51. Do you feel happy most of the time?	YES / NO			
52. Do you feel you have more problems with memory than most?	YES / NO			

53. Do you think it is wonderful to be alive now?	YES / NO	
54. Do you think most people are better off than you?	YES / NO	
55. Do you feel that your situation is hopeless?	YES / NO	
56. Do you feel full of energy?	YES / NO	

Finally I am going to ask you about how you feel about your overall health and support RIGHT NOW at this present time.

57. In general, would you say that your health is……. **excellent** **very good** **good** **fair** **poor**			Excellent ☐ very good ☐ good ☐ fair ☐ poor ☐
58. Do you experience a general sense of emptiness?	YES	MORE OR LESS	NO
59. Do you miss having people around me?	YES	MORE OR LESS	NO
60. Do you often feel rejected?	YES	MORE OR LESS	NO
61. Are there plenty of people you can rely on when you have problems?	YES	MORE OR LESS	NO
62. Are there many people you can trust completely?	YES	MORE OR LESS	NO

63. Are there enough people you feel close to?	YES	MORE OR LESS	NO

Thank you for answering these questions. The questionnaire is now completed!

---------- END OF INTERVIEW ----------

Exploring the impact of activities and relationships on all stakeholders residing, working and visiting Residential and Nursing Care homes across South Wales

Older adults Questionnaire and manual (T2)

SECTION A

Care Home Name: _____

Name of Interviewee: _____

Participants Number: _____

Date of Interview: _____

INTERVIEW STATUS □Complete □Incomplete

Reason why interview is incomplete (if applicable)

□ Resident fatigue □ Unable to respond to questions
□ Refusal to continue □ Necessary clinical care
□ Resident illness □ Other

---------- START OF QUESTIONNAIRE ----------

Thank you for agreeing to be interviewed. Your help is extremely valuable to us and of course any information you provide will be treated in strictest confidence.
The purpose of this interview is to find out a little more about you and your feelings. In some of the questions at the beginning you will be asked to engage in activities such as copying images presented to you, word recall and other memory tasks. You are able to stop the interview at any point in time.
Are you still happy to go ahead with these questions?

I want you to think about the next few questions in relation to how you felt last week. First I am going to ask about your feelings. So, in the last week, have you felt….(CIRCLE ANSWER)				
1. Cheerful?	A lot	Quite a bit	A little	Not at all
2. Worried or anxious	A lot	Quite a bit	A little	Not at all
3. That you are enjoying life?	A lot	Quite a bit	A little	Not at all
4. Frustrated?	A lot	Quite a bit	A little	Not at all
5. Confident?	A lot	Quite a bit	A little	Not at all
6. Full of energy?	A lot	Quite a bit	A little	Not at all
7. Sad?	A lot	Quite a bit	A little	Not at all
8. Lonely?	A lot	Quite a bit	A little	Not at all
9. Distressed?	A lot	Quite a bit	A little	Not at all
10. Lively?	A lot	Quite a bit	A little	Not at all
11.. Irritable?	A lot	Quite a bit	A little	Not at all
12. Fed-up?	A lot	Quite a bit	A little	Not at all

13. That there are things that you wanted to do but couldn't?	A lot	Quite a bit	A little	Not at all
Next im going to ask about your memory. In the last week, how worried have you been about……				
14. Forgetting things that happened recently?	A lot	Quite a bit	A little	Not at all
15. Forgetting who people are?	A lot	Quite a bit	A little	Not at all
16. Forgetting what day it is?	A lot	Quite a bit	A little	Not at all
17. Your thoughts being muddled?	A lot	Quite a bit	A little	Not at all
18. Difficulty making decisions?	A lot	Quite a bit	A little	Not at all
19. Poor concentration?	A lot	Quite a bit	A little	Not at all
Now im going to ask you about your everyday life. In the last week, how worried have you been about?.....				
20. Not having enough company?	A lot	Quite a bit	A little	Not at all
21. How you get on with people close to you?	A lot	Quite a bit	A little	Not at all
22. Getting the affection you want?	A lot	Quite a bit	A little	Not at all
23. People not listening to you?	A lot	Quite a bit	A little	Not at all
24. Making yourself understood?	A lot	Quite a bit	A little	Not at all
25. Getting help when you need it?	A lot	Quite a bit	A little	Not at all
26. Getting to the toilet in time?	A lot	Quite a bit	A little	Not at all

27. How you feel in yourself?	A lot	Quite a bit	A little	Not at all
28. Your health overall?	A lot	Quite a bit	A little	Not at all
We've already talked about lots of things: your feelings, memory, and everyday life. Thinking about all of these things in the last week, how would you rate……				
29. Your overall quality of life?	Very good	Good	Fair	Poor

Now we would like to ask you some general questions about your time living here in the care home, aswell as your health and wellbeing.

I am going to read out a number of statements and I would like you to indicate the answer that best describes to what extent each statement is true for you, on this scale. (Show the response card and ask the participant to say or point to the answer, and circle appropriate answer).	Rarely	Sometimes	Usually	Always
30. The activities you do help you take care of yourself.	Rarely	Sometimes	Usually	Always
31. The activities you do reflect the kind of person you are.	Rarely	Sometimes	Usually	Always
32. The activities you do express your creativity	Rarely	Sometimes	Usually	Always
33. The activities you do help me achieve something which gives you a sense of accomplishment.	Rarely	Sometimes	Usually	Always

34. The activities you do contribute to you feeling competent.	Rarely	Sometimes	Usually	Always
35. The activities you do are valued by other people.	Rarely	Sometimes	Usually	Always
36. The activities you do help other people.	Rarely	Sometimes	Usually	Always
37. The activities you do give you pleasure	Rarely	Sometimes	Usually	Always
38. The activities you do give you a feeling of control.	Rarely	Sometimes	Usually	Always
39. The activities you do help you express my personal values.	Rarely	Sometimes	Usually	Always
40. The activities you do give you a sense of satisfaction.	Rarely	Sometimes	Usually	Always
41. The activities you do have just the right amount of challenge	Rarely	Sometimes	Usually	Always
42. Are you basically satisfied with your life?	YES / NO			
43. Do you often get bored?	YES / NO			
44. Do you often feel helpless?	YES / NO			
45. Do you prefer to stay at home, rather than going out and doing new things?	YES / NO			
46. Do you feel pretty worthless the way you are now?	YES / NO			

47. Have you dropped many of your activities and interests?	YES / NO
48. Do you feel your life is empty?	YES / NO
49. Are you in good spirits most of the time?	YES / NO
50. Are you afraid something bad is going to happen to you?	YES / NO
51. Do you feel happy most of the time?	YES / NO
52. Do you feel you have more problems with memory than most?	YES / NO
53. Do you think it is wonderful to be alive now?	YES / NO
54. Do you think most people are better off than you?	YES / NO
55. Do you feel that your situation is hopeless?	YES / NO
56. Do you feel full of energy?	YES / NO

We are now going to ask you about how you feel about your overall health and support RIGHT NOW at this present time and your relationships.

57. In general, would you say that your health is…….		**Excellent** ☐ **Very good** ☐ **Good** ☐ **Fair** ☐ **Poor** ☐	
58. There are enough people I feel close to	YES	MORE OR LESS	NO
59. I miss having people around me	YES	MORE OR LESS	NO

60. I often feel rejected	YES	MORE OR LESS	NO
61. There are many people I can trust completely	YES	MORE OR LESS	NO
62. I experience a general sense of emptiness	YES	MORE OR LESS	NO
63. There are plenty of people I can rely on when I have problems	YES	MORE OR LESS	NO

The next section, which is the last, will ask you about your feedback and experiences of the activities being run in the care home.

64. Has there been anything in particular you enjoy about the activities?

☐ Yes ☐ No **If YES, please can you explain further.**

☐ Yes ☐ No **If YES, please can you explain further.**

66. To what extent do you agree that the following were appropriate?

	Strongly Agree	Agree	No strong Opinion	Disagree	Strongly Disagree	I don't Know
Number of Sessions						
Duration of Session						

Time of Day						
Ratio of Staff/Facilitators to Participants						
The facilities						
Total Number of Participants						

67. Would you say the activities run in the care home have changed your relationship or communication with the care staff in any way?

Relationships: Yes ☐ No ☐ **If yes, please explain further**

Communication: Yes ☐ No ☐ **If yes, please explain further**

68. To what extent do you agree with the following statements.

	Strongly Agree	Agree	No strong Opinion	Disagree	Strongly Disagree	I don't Know
You were well informed of the activities being run						

You had input and choice into the type of activities that were being run						
The activities have been worthwhile						
The activities lifted the atmosphere/spirit of the care home						
The staff tried to engage as many residents as possible						
You would like more contact with children in the care home						

69. Overall, how satisfied have you been with the activities?

Very Satisfied	Satisfied	Neither satisfied nor unsatisfied	Unsatisfied	Very Unsatisfied
○	○	○	○	○

Any other comments…

---------- END OF INTERVIEW ----------

Appendix 9 - Younger persons questionnaires

Younger persons Questionnaire (T1/T3)

Date _____

Participant Name _____

Participant ID _____

Name of school/group_____

◯ Male

◯ Female

◯ Non- Binary

◯ Prefer not to say

Age _____

---------- START OF INTERVIEW ----------

1. Have you ever visited a care home before?

☐ Yes If yes, How many times? _____

☐ No

2. Do you have any grandparents/ Grandmother / Grandfather?

☐ **Yes** IF YES- **How often do you visit them**? Daily ☐

☐

No Weekly ☐

☐

Monthly

3. Who lives at home with you?

WORD ASSOSIATION - **Now I am going to ask you about older people.**			
3. What can you tell me about old people?	*Frequency Count…*	Positive	Negative
	Affective responses		
	Behavioural responses		
	Physical responses		
Note response:			

4. What old people do you know?	Family: ☐ Yes ☐ No Others: ☐ Yes ☐ No
5. What do you do with that person?	With – Active: ☐ Yes ☐ No With – Passive: ☐ Yes ☐ No For: ☐ Yes ☐ No
Note response:	
6. Can you give me another name for old people?	☐ Yes ☐ No
Note response:	
7. How do you feel about getting old?	☐ Positive ☐ Neutral ☐ Negative ☐ Don't Know/No response
Note response:	
PICTURE SERIES - **Now I am going to show you some pictures…..**	
Photographs to be shuffled and placed in random order on the testing table	
	Response (Ability to identify):

8. Which person do you think is the oldest? **9. Why?**	☐ Yes ☐ No Response: ☐ Evaluative ☐ Physically descriptive ☐ Don't Know/No reponse
Photographs remain on table.	
Directions: - If child has identified correctly in (A), examiner continues. - If child has failed to Identify, examiner points to photograph of oldest man. **10. How will you feel when you are that old?**	Response: ☐ Positive ☐ Neutral ☐ Negative ☐ Don't Know/ No response
Note responses:	
Directions: - Examiner points to the oldest person **11. What things would you help this person do?**	Response: ☐ Affective ☐ Behavioural stereotype ☐ Behavioural unique ☐ Don't Know/ No response

Directions: - Examiner points to the oldest person **12. What things could he help you do?**	Response: ☐ Affective ☐ Behavioural stereotype ☐ Don't Know/ No response
Note Response	
Directions: - Photographs remain on testing table in random order. **13. Can you put these pictures in order from youngest to oldest?**	Response: (Ability to order) ☐ Yes ☐ No
Directions: - Photographs are placed in proper sequence. Examiner points to photographs, one at a time in correct order. **14. How old do you think each of these men are? Record a ctual age.**	Photograph 1 (Youngest) _____ Photograph 2 (2nd Youngest) _____ Photograph 3 (2nd Oldest) _____ Photograph 4 (Oldest) _____

Directions: - Examiner indicates all four photographs. **15. Which of these people would you prefer to be with?** **16. Why?**	Response: ☐ Photograph 1 (Youngest) ☐ Photograph 2 (2nd Youngest) ☐ Photograph 3 (2nd Oldest) ☐ Photograph 4 (Oldest) Response: ☐ Age related ☐ Altruistic ☐ Evaluative ☐ Don't Know/ No response
Note response:	
Directions: - Examiner points to photograph chosen in question 13. **17. What kinds of things could you do with that person?**	Response: ☐ With - Active ☐ With – Passive ☐ For

SEMANTIC DIFFERENTIAL

Directions: Show participant the scale and circle their response accordingly.

Young people are…….

	Very		A little		Very	
Helpful	1	2	3	4	5	**Harmful**
Sick	1	2	3	4	5	**Healthy**
Rich	1	2	3	4	5	**Poor**
Dirty	1	2	3	4	5	**Clean**
Friendly	1	2	3	4	5	**Unfriendly**
Ugly	1	2	3	4	5	**Pretty**
Wonderful	1	2	3	4	5	**Terrible**
Wrong	1	2	3	4	5	**Right**
Happy	1	2	3	4	5	**Sad**
Bad	1	2	3	4	5	**Good**

Old people are….

	Very		A little		Very	
Helpful	1	2	3	4	5	**Harmful**
Sick	1	2	3	4	5	**Healthy**
Rich	1	2	3	4	5	**Poor**
Dirty	1	2	3	4	5	**Clean**
Friendly	1	2	3	4	5	**Unfriendly**
Ugly	1	2	3	4	5	**Pretty**
Wonderful	1	2	3	4	5	**Terrible**
Wrong	1	2	3	4	5	**Right**
Happy	1	2	3	4	5	**Sad**
Bad	1	2	3	4	5	**Good**

Thank you for taking your time to answer these questions, we have now finished.

---------- END OF INTERVIEW ----------

Younger persons Questionnaire (T2)

Date _____

Participant Name _____

Participant ID _____

Name of school/group_____

- ◯ Male
- ◯ Female
- ◯ Non- Binary
- ◯ Prefer not to say

Age _____

---------- START OF INTERVIEW ----------

4. Do you have any grandparents/ Grandmother / Grandfather?

☐ **Yes** IF YES- **How often do you visit them**? Daily ☐

☐

No Weekly ☐

☐

Monthly

5. Who lives at home with you?

WORD ASSOSIATION - **Now I am going to ask you about older people.**			
3. What can you tell me about old people?	*Frequency Count…*	Positive	Negative
	Affective responses		
	Behavioural responses		
	Physical responses		
Note response:			
4. What old people do you know?	Family: ☐ Yes ☐ No	Others: ☐ Yes ☐ No	

5. What do you do with that person?	With – Active: ☐ Yes ☐ No With – Passive: ☐ Yes ☐ No For: ☐ Yes ☐ No
Note response:	
6. Can you give me another name for old people?	☐ Yes ☐ No
Note response:	
7. How do you feel about getting old?	☐ Positive ☐ Neutral ☐ Negative ☐ Don't Know/No response
Note response:	
PICTURE SERIES - **Now I am going to show you some pictures…..**	
Photographs to be shuffled and placed in random order on the testing table	
10. Which person do you think is the oldest? **11. Why?**	Response (Ability to identify): ☐ Yes ☐ No

	Response: ☐ Evaluative ☐ Physically descriptive ☐ Don't Know/No reponse
Photographs remain on table.	
Directions: - If child has identified correctly in (A), examiner continues. - If child has failed to Identify, examiner points to photograph of oldest man. **10. How will you feel when you are that old?**	Response: ☐ Positive ☐ Neutral ☐ Negative ☐ Don't Know/ No response
Note responses:	
Directions: - Examiner points to the oldest person **11. What things would you help this person do?**	Response: ☐ Affective ☐ Behavioural stereotype ☐ Behavioural unique ☐ Don't Know/ No response
Directions: - Examiner points to the oldest person **12. What things could he help you do?**	Response: ☐ Affective ☐ Behavioural stereotype ☐ Don't Know/ No response

Note Response:	
Directions: - Photographs remain on testing table in random order. **13. Can you put these pictures in order from youngest to oldest?**	Response: (Ability to order) ☐ Yes ☐ No
Directions: - Photographs are placed in proper sequence. Examiner points to photographs, one at a time in correct order. **14. How old do you think each of these men are? Record actual age.**	Photograph 1 (Youngest) _____ Photograph 2 (2nd Youngest) _____ Photograph 3 (2nd Oldest) _____ Photograph 4 (Oldest) _____
Directions: - Examiner indicates all four photographs. **15. Which of these people would you prefer to be with?** **17. Why?**	Response: ☐ Photograph 1 (Youngest) ☐ Photograph 2 (2nd Youngest) ☐ Photograph 3 (2nd Oldest) ☐ Photograph 4 (Oldest) Response: ☐ Age related ☐ Altruistic ☐ Evaluative ☐ Don't Know/ No response

Note response:	
Directions: - Examiner points to photograph chosen in question 13. **17. What kinds of things could you do with that person?**	Response: ☐ With - Active ☐ With – Passive ☐ For

SEMANTIC DIFFERENTIAL						
Directions: Show participant the scale and circle their response accordingly. **Young people are…….**						
	Very		A little		Very	
Helpful	1	2	3	4	5	**Harmful**
Sick	1	2	3	4	5	**Healthy**
Rich	1	2	3	4	5	**Poor**
Dirty	1	2	3	4	5	**Clean**

Friendly	1	2	3	4	5	**Unfriendly**
Ugly	1	2	3	4	5	**Pretty**
Wonderful	1	2	3	4	5	**Terrible**
Wrong	1	2	3	4	5	**Right**
Happy	1	2	3	4	5	**Sad**
Bad	1	2	3	4	5	**Good**

Old people are….						
	Very		A little		Very	
Helpful	1	2	3	4	5	**Harmful**
Sick	1	2	3	4	5	**Healthy**
Rich	1	2	3	4	5	**Poor**
Dirty	1	2	3	4	5	**Clean**
Friendly	1	2	3	4	5	**Unfriendly**

Ugly	1	2	3	4	5	**Pretty**
Wonderful	1	2	3	4	5	**Terrible**
Wrong	1	2	3	4	5	**Right**
Happy	1	2	3	4	5	**Sad**
Bad	1	2	3	4	5	**Good**

I would now like to ask you some questions about what you thought of going to visit the old people in the care home……

18. you enjoy the visiting the care home? Yes ☐ No ☐

19. What did you like about it?

20. What did you dislike about it?

21. What are the main things you think you've learnt/gained from the activities with the older adults?

22. Would you like to keep going back to the care home?

Yes ☐

No ☐

I don't know ☐

23. If you could describe visiting the care home in three words, what would you say?

1. _____ 2. _____ 3._____

24. Would you prefer opportunities to play with people of different age groups or just with friends in your group?

Different Ages ☐ **Just friends my age** ☐ **I don't know** ☐

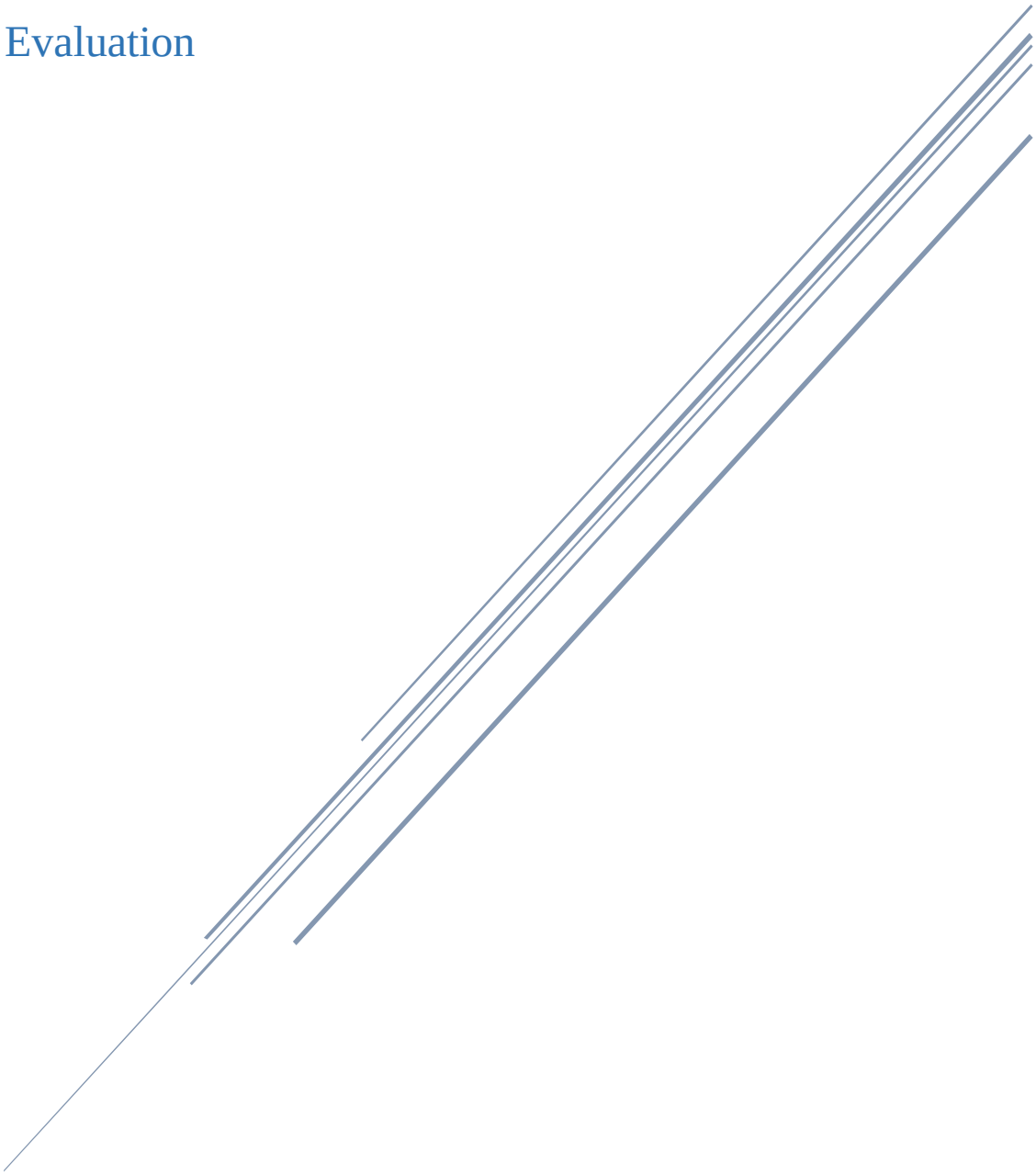
Thank you for taking your time to answer these questions, we have now finished.

---------- END OF INTERVIEW ----------

Appendix 10 – Facilitator feildnote booklet

PROGRAMME SESSION SUMMARY BOOKLET

Process Evaluation



Session 1

Date:

Time of Session: Length of Session:

Number and type of staff present at session: (please mark box below)

Teacher/s	Group Leader	Activity Co-coordinator	Care home Manger	Care staff	Other

Summary of Session:

Name of individuals in Attendance:

Older adults	Younger Individuals

Session 2

Date:

Time of Session: Length of Session:

Number and type of staff present at session: (please mark box below)

Teacher/s	Group Leader	Activity Co-coordinator	Care home Manger	Care staff	Other

Summary of Session:

Name of individuals in Attendance:

Older adults	Younger Individuals

Session 3

Date:

Time of Session: Length of Session:

Number and type of staff present at session: (please mark box below)

Teacher/s	Group Leader	Activity Co-coordinator	Care home Manger	Care staff	Other

Summary of Session:

Name of individuals in Attendance:

Older adults	Younger Individuals

Session 4

Date:

Time of Session: Length of Session:

Number and type of staff present at session: (please mark box below)

Teacher/s	Group Leader	Activity Co-coordinator	Care home Manger	Care staff	Other

Summary of Session:

Name of individuals in Attendance:

Older adults	Younger Individuals

Session 5

Date:

Time of Session: Length of Session:

Number and type of staff present at session: (please mark box below)

Teacher/s	Group Leader	Activity Co-coordinator	Care home Manger	Care staff	Other

Summary of Session:

Name of individuals in Attendance:

Older adults	Younger Individuals

Session 6

Date:

Time of Session: Length of Session:

Number and type of staff present at session: (please mark box below)

Teacher/s	Group Leader	Activity Co-coordinator	Care home Manger	Care staff	Other

Summary of Session:

Name of individuals in Attendance:

Older adults	Younger Individuals

Session 7

Date:

Time of Session: Length of Session:

Number and type of staff present at session: (please mark box below)

Teacher/s	Group Leader	Activity Co-coordinator	Care home Manger	Care staff	Other

Summary of Session:

Name of individuals in Attendance:

Older adults	Younger Individuals

Session 8

Date:

Time of Session: Length of Session:

Number and type of staff present at session: (please mark box below)

Teacher/s	Group Leader	Activity Co-coordinator	Care home Manger	Care staff	Other

Summary of Session:

Name of individuals in Attendance:

Older adults	Younger Individuals